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159
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Public Hearing

before

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

"The New Jersey Health Care Trust Fund and
Alternative Means of Funding Hospital Uncompensated Care"

LOCATION: The Valley Hospital
Kraft Auditorium
Ridgewood, New Jersey

DATE: March 5, 1992
3:30 p.m.

New Jersey State Library

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Nicholas R. Felice, Vice-Chairman
Assemblyman Stephen A. Mikulak
Assemblyman Thomas Smith
Assemblywoman Barbara Wright
Assemblyman Louis A. Romano



ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and
Human Services Committee

Hearing Recorded and Transcribed by

The Office of Legislative Services, Public Information Office,
Hearing Unit, 162 W. State St., CN 068, Trenton, New Jersey 08625-0068





Harold L. Colburn, Jr.
CHAIRMAN

Nicholas R. Felice
VICE-CHAIRMAN

Stephen A. Mikulak

Thomas Smith

Barbara Wright

Stephanie R. Bush

Louis A. Romano

New Jersey State Legislature
ASSEMBLY HEALTH AND HUMAN
SERVICES COMMITTEE
Legislative Office Building, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 292-1646

NOTICE OF A PUBLIC HEARING

The Assembly Health and Human Services Committee will hold a public hearing on the following issue:

**The New Jersey Health Care Trust Fund
and Alternative Means of Funding Hospital Uncompensated Care**

The hearing will be held on Thursday, March 5, 1992, from 3:30 P.M. to 7:30 P.M., in the Kraft Auditorium of The Valley Hospital, 223 North Van Dien Avenue, Ridgewood, N.J. (201-447-8000). The auditorium is in the basement of the Bergen Pavilion.

The public may address comments and questions to David Price, Committee Aide and persons wishing to testify should contact Felice Astor, secretary, at (609) 292-1646. Those persons presenting written testimony should provide 12 copies to the committee on the day of the hearing.

Issued 2/6/91



LEGISLATURE OF THE STATE OF OREGON
 HEALTH AND HUMAN SERVICES COMMITTEE
 1000 NE Oregon Street, Suite 200
 Portland, Oregon 97232

Harold J. Colburn, Jr.
 Chairman
 Nicholas P. Fallick
 Stephen A. Foxworth
 Thomas Griffin
 Richard W. Wright
 Stephanie A. Bush
 Louis A. Romano

NOTICE OF A PUBLIC HEARING

The Assembly Health and Human Services Committee will hold a public hearing on the following:

The Valley Health Care Trust Fund and Alternative Methods of Funding Hospital Uncompensated Care

The hearing will be held on Thursday, March 2, 1995, from 1:30 P.M. to 7:30 P.M. in the hearing room of the Valley Health Care Trust Fund, 228 North Van Dine Avenue, Ridgecrest, O.R. (503-447-8000). The auditorium is in the basement of the building.

The public may make comments and questions to David Piles, Committee Aide and hearing officer, by calling to testify should contact Piles at 503-447-8000. Those persons presenting written testimony should provide 12 copies to the committee on the day of the hearing.

Issued 2/27/95

TABLE OF CONTENTS

	<u>Page</u>
Victoria A. Wicks President and Chief Executive Officer HIP/Rutgers Health Plan	3
Charles A. Mowl Vice-President Finance New Jersey Hospital Association	7
Kathleen Brennan Director Health Care Program for the Uninsured New Jersey Department of Health	23
Assemblywoman Charlotte Vandervalk District 39	30
Bruce G. Coe President New Jersey Business & Industry Association	33
James C. Morford Vice-President Government Relations New Jersey State Chamber of Commerce	45
Thomas E. Terrill, Ph.D. Executive Vice-President University Health System of New Jersey	54
Marc H. Lory Vice-President and Chief Executive Officer University of Medicine & Dentistry of New Jersey	61
Melanie Willoughby President New Jersey Retail Merchants Association and Co-Chair Help Establish Affordable Health Care Laws Coalition (HEAL)	69

	President and Chief Executive Officer Hibernia Health Plan	
	Charles A. Mowll Vice-President Finance New Jersey Hospital Assn	
	Kathleen Brennan Director Health Care Program for New Jersey Department of	28
	Assemblywoman Charlotte District 12	30
	Bruce G. Goe President New Jersey Business & Industry Assn	33
	James C. Norford Vice-President Government Relations New Jersey State Chamber of Commerce	48
	Thomas E. Terriff, Ph.D. Executive Vice-President University Health System - Jersey	54
	Marc H. Lory Vice-President and Chief Executive Officer University of Medicine & Dentistry of New Jersey	61
	Melanie Wiltonsky President New Jersey Health Care Access Assn	
	John J. Afford New Jersey Law Coalition	

TABLE OF CONTENTS (continued)

Page

Maureen Lopes
 Vice-President
 Health Affairs
 New Jersey
 Business & Industry Association and
 Co-Chair
 Help Establish Affordable
 Health Care Laws Coalition (HEAL) 72

Timothy Harrington
 President
 MA Resources
 Mid-Atlantic Health Group 79

Robert Ragona
 Director of Finance
 Bergen Pines County Hospital 83

E. Von Lindern
 Past President
 Mental Health Advocacy Group 86

Gerald Tofani
 Vice President
 Finance
 St. Peter's Medical Center 89

APPENDIX:

Newspaper Article plus
 attachments submitted by
 Victoria A. Wicks 1x

Statement submitted by
 Charles A. Mowll 5x

Statement submitted by
 Bruce G. Coe 17x

Statement submitted by
 Melanie Willoughby
 and Maureen Lopes 23x

* * * * *

tca: 1-22
 bgs: 23-44
 mjz: 45-92

TABLE OF CONTENTS (continued)

Page

	Health Care Laws Coalition (HCLC)	72
	Help Establish Affordable Care Act	
	Co-Chair	
	Business & Industry Action	
	New Jersey	
	Health Affairs	
	Vice President	
	Robert Lopez	
	Timothy Harrington	
	President	
	MA Resources	
79	Mid-Atlantic Health Care	
	Robert Rogers	
	Director of Finance	
83	Bergen Pines County Health	
	EA Von Linden	
	CEO	
88	Health Care Advocacy	
	Gerold Tolani	
	Vice President	
	Finance	
89	St. Peter's Medical Center	
APPENDIX:		
	Newspaper Article plus	
ix	attachments submitted by	
	Victoria A. Wicks	
	Statement submitted by	
ix	Charles A. Mowll	
	Statement submitted by	
ix	Eric S. Coe	
	Statement submitted by	
ix	Kelley M. Loughry	
	and Karen Lopez	

Page 1-22
 Page 23-44
 Page 45-92

ASSEMBLYMAN HAROLD L. COLBURN, JR. (Chairman): I'd like to get started, if we could, with our public hearing this afternoon. This, as you know, is a public hearing on the problem of hospital uncompensated care.

I appreciate the fact that the hospital has let us attend. I think I saw the Administrator here earlier, but I'm not sure I see him now. Is there anybody here representing the hospital, that's been very kind to us in allowing us to be here? (no response) I guess not. But we thank them, and I hope we don't drop too many soda bottles or abuse their nice place.

I wanted to say for myself that I feel that hospital care cost shifting is public enemy number one when it comes to health care financing in the country today. So, I call that public enemy number one. Of course, in that category of things is uncompensated care which presents something like \$700 million or \$800 million shifted from people who don't or can't pay to those who do pay, and it does increase the cost of medical care significantly.

In addition to uncompensated hospital care, cost shifting is heavy for Medicare. Medicare doesn't pay for the services of people in the hospital and increasingly it's a problem. It's a cost shift from the Federal government to us, and so far we haven't been able to do very much about it. I think we need to address that more strongly and make a lot more noise about it, and whether we'll be successful or not, of course, I don't know. Then other programs underpay various people. The Medicaid program, historically, from 20 years ago, has not paid providers anywhere near what their costs were, and more and more providers drop out. So, unfortunately, that's a cost shift to the rest of us, and no care for a lot of people, which is very unfortunate.

I've also questioned the cost shift that takes place when some payers get a discount for hospital care and,

therefore, don't pay even their share towards uncompensated care. Then we go on and on with -- maybe -- physicians charging too much, other people charging too much, lots of home health care services getting expensive, and the whole system, of course, is not only confused, but we're here today to deal with one part of it.

As you may remember, the Uncompensated Care Trust Fund started up in '86 or '87, and I was wisely -- or unwisely -- the original sponsor of the bill under the Kean administration. I refused to sponsor the continuation of the program, however, because I didn't feel that the surcharges were manageable at all. They had gone up, I guess, to 12 percent or 13 percent at that time, and I was very unhappy with the amount of documentation and accountability that was within the system. I and my staff tried repeatedly to get such information from the Department of Health at that time, and we were frustrated at every turn. I did vote for the continuation of the program because I couldn't think of anything better at the time, but it was very unsatisfactory.

I am grateful to the present Health Commissioner, Dr. Dunston, and to the people in the Governor's Office for their cooperation thus far in supplying us with much better information than we've ever had before. I hope that continues because this is such a huge problem that it does require cooperation and help among all of us to try to do something about the problem. So, I acknowledge publicly that they have improved the performance of the Executive branch, in this matter, and I do appreciate it.

I just wanted to say those few things before I turn this over to Assemblyman Nick Felice, who's Vice-Chairperson of our Committee. He's a longtime leader in health care legislation, and of course this is your district, Nick?

ASSEMBLYMAN FELICE: Yes.

ASSEMBLYMAN COLBURN: Is it?

ASSEMBLYMAN FELICE: Yes it is.

ASSEMBLYMAN COLBURN: He knows the subject. He knows the people here, and he's got his list of people to testify, so I'm going to back away from this. I thank all of you for coming.

Wait, we ought to introduce our members. This is Nick Felice, Steve Mikulak, Tom Smith, Barbara Wright, and where is our Mr. Romano?

ASSEMBLYMAN FELICE: There he is.

ASSEMBLYMAN COLBURN: This man has the best cough drops of anybody in the Assembly. (laughter) He saved my voice at the last meeting we had.

ASSEMBLYMAN FELICE: Okay.

ASSEMBLYMAN COLBURN: Let's go.

ASSEMBLYMAN FELICE: Thank you very much, Dr. Colburn. I'm glad you said, not the oldest member of the Health Committee. We have a very interesting group of speakers today. We'd like to get right on to that. I know that some people have time priorities. I would like to start off with Victoria Wicks, the President of HIP/Rutgers Health Plan, if she would? I think you have your copies of her statement here in front of you -- the testimony.

V I C T O R I A A. W I C K S: Thank you. Mr. Chairman and members of the Committee: Thank you for the opportunity to appear this afternoon, to provide a managed care perspective on an issue that is vital to the health care needs of our State's residents. I am Victoria Wicks, President and CEO of HIP/Rutgers Health Plan, New Jersey's largest multi-specialty group practice health maintenance organization, serving over 175,000 members in 13 health care centers located as far south as Gloucester County, and as far north as Bergen County.

Your Committee has posed the question, "What alternatives exist to fund hospitals' uncompensated care debt?" We believe there is a workable answer. We must remove

from the uncompensated care rolls all of those but the 10 percent who are truly indigent. To solve this major problem we need only remove the barriers, which currently exist that preclude most of those categorized as bad debt, from purchasing health insurance or from participating in a managed care program.

The more people who can obtain reasonable insurance coverage, the fewer people will be dependent on the Uncompensated Care Trust Fund. I'll call attention -- for those of you who didn't have an opportunity to see -- for example, the front page article of The New York Times yesterday, which talked about-- I'll pass the copies up here. It talked specifically about a family that was covered by a large group, for their health insurance coverage, where one member of the family -- it happened to be a child -- had an illness that was preventing them from being able to get access to affordable and accessible health insurance. That has been traditionally called a small group insurance problem -- what I'm going to refer to later on in my remarks. However, for the first time, we're seeing in a major publication reference to this problem now coming to the large group market as well. It certainly is something of a serious nature for everyone across the country, not only those of us in New Jersey.

To solve this major-- These barriers that we talk about constitute the major reason why health insurance is out of financial reach for so many. Here's why: Currently, health insurers are allowed to segment the small group market into various high and low risk clusters based on such factors as age, gender, and workplace -- both in a geographic and professional sense. This ability to "experience rate," results in insurers -- what we call -- "cherry picking" from the low risks groups, and either ignoring or charging outrageous premiums to those categorized as high risk. Despite the common belief that only those working in the most hazardous

professions and those most sick are considered to be high risk for insurance purposes, the real story may surprise you.

According to a recent Robert Wood Johnson Foundation study, a chart of which I think I have attached to my remarks for you, shows industries often excluded from health insurance plans that include: auto dealers, barber shops, beauty shops, florists, grocery stores, restaurants, taverns, law firms, interior decorators, hotels, motels, physicians' offices -- Dr. Colburn--

ASSEMBLYMAN COLBURN: I've heard that many times before. (laughter)

MS. WICKS: --and ironically, the insurance agencies themselves. If we eliminate an insurer's ability to make these classifications of high risk and low risk, if we consider the small group market as a single group over which truly high risk cases can be spread, then we have removed a major barrier to health insurance affordability.

Mr. Chairman, and members of this Committee, there is another barrier to making small group insurance both affordable and available: It's the current practice of imposing exclusions for preexisting conditions. How many women forgo much needed prenatal care because they became pregnant prior to the beginning of an insurance sign-up period? This sad reality exists today in New Jersey. And I can tell you personally, as a mother of two small children, if I were in a circumstance where my coverage began -- either through my employer or through my husband's -- and I was going to be excluded -- if I were already pregnant at the time my insurance became enforced -- for what's traditionally a period of 12 months for a preexisting condition, I would have no insurance coverage for the entire term of that pregnancy, and if I didn't have the financial wherewithal, I would be tempted to go without prenatal care. Not only does that endanger the mother in those circumstances, but as all of us know, it certainly puts the

child at risk -- what ends up to be not only an emotionally unnecessary situation but certainly one that doesn't make sense financially.

During prenatal care, mothers who do not get adequate prenatal care frequently are at risk for having sick babies at the time they are born -- not a situation that makes a lot of sense. I believe moderate premiums can be assured if we define small group benefits to include only those services which are essential, and preclude the mandating of additional benefits. Mandated benefits contribute significantly to higher health insurance rates. We must make sure that all small group carriers abide by these same set of rules, so that we protect both employers and consumers from losing health care coverage.

To ensure competitive fairness among health insurers, all of these carriers must be permitted to operate on a level playing field, by the same rules. If these barriers are removed, would both small and business health insurance become affordable? Absolutely. I'm sure of that because HIP/Rutgers Health Plan, and all other HMOs in New Jersey function, and function well, in barrier-free settings.

If one of our members come to us in her third trimester of pregnancy, we provide prenatal care, deliver the baby, and provide postpartum care. If a member comes to us with cancer we provide coordinated care through our specialists. Even if a member works in a factory where hazardous fumes may be present, we provide care too, and we provide this comprehensive care at rates which are lower than most people pay.

If individuals could be assured of a continuum of care for say only \$1500 a year, or families for only \$4500 a year, this would permit their access to a personal doctor who knows their condition and knows their history, instead of a continued reliance on hospital emergency rooms in our State, as their primary care providers. HIP/Rutgers Health Plan stands ready

to work with you; the Committee, to break down the barriers and give residents throughout New Jersey a real opportunity to access affordable and renewable health insurance. Thank you very much.

ASSEMBLYMAN FELICE: Thank you, Victoria. I'm going to ask -- if you would a moment, I know you have to leave -- the members of the Committee if they have any questions for Victoria? (no response) None. Thank you very much.

MS. WICKS: Thank you very much.

ASSEMBLYMAN FELICE: At this time, did anyone from the Department of Health, any of the representatives, show up? (no response) Then we'll go on to the next one. Bruce Coe, President of New Jersey Business and Industry. (no response) He hasn't shown up yet? (no response) Okay, we'll go to James Morford, Vice-President for Government Relations in the New Jersey State Chamber of Commerce? (no response) I guess they're having a tough time finding the place. Chuck Mowll, Vice President of Finance, New Jersey Hospital Association. I know they're here.

C H A R L E S A. M O W L L: Mr. Chairman, and members of the Assembly Health and Human Services Committee, I appreciate the opportunity to address you here this afternoon on an extremely important issue to New Jersey's hospitals.

I'm Chuck Mowll, the Vice President of the New Jersey Hospital Association, and will represent our member hospitals in these comments. Before I discuss the details of some specific recommendations and concerns that we have identified in our written comments that I'll review here in the next few minutes, I'd like to just say two things:

One, the situation has changed in regard to the Uncompensated Care Trust Fund, dramatically, since last year. We are now bringing to the State of New Jersey approximately \$350 million to \$400 million of additional revenue through the new Medicaid Contributions Plan, which was added to the Health Care Cost Reduction Act as it was written last year.

This innovative new mechanism has helped bring revenues to New Jersey that we have not seen before, and is clearly very delicately balanced with the current structure of the Health Care Trust Fund, and that's something that I think that we have to review; our suggestions and recommendation from the Association, and any other recommendations and suggestions that you will receive over the next few months, and the relationship they have with the protections of these revenues coming to New Jersey. As I understand it, the Health Care Financing Authority in Baltimore is keeping a close watch on those states who are participating in these programs, and New Jersey is just one of them.

Secondly, I'd like to commend you, Mr. Chairman, and the members of this Committee, for opening up the discussions and dialogue on this very, very important issue, to the hospitals and to the citizens we serve. The segment of the population that this Trust Fund serves and provides care to is a population that doesn't have a strong and vocal lobby. They are a silent group of poor, medically indigent, and the uninsured. Therefore, I think your charge is an extremely important one, and I know you've been challenged -- in 1988 and again in 1990 as the Trust Fund lapsed -- to come up with an intelligent solution to the extension of a Trust Fund, and that's been a hard job for you.

The Hospital Association's position regarding the Uncompensated Care Trust Fund has been consistently and clearly articulated over the many years of public debate. We, again, support this important funding mechanism -- a mechanism which ensures access to hospital care to the least fortunate of our State's residents.

The Hospital Association wholeheartedly endorses the continuation of an Uncompensated Care Trust Fund to address the very issues identified in the preamble of the current Health Care Cost Reduction Act. In the quote I have exerted there:

"Access to quality health care shall not be denied to residents of the State because of their inability to pay for the care." This is unique to New Jersey. We should be proud of it, and we are.

Furthermore, the Fund objectives are clearly defined in the current Fund, on page three. The first one is: To ensure equal access to hospital care, maintain a mechanism that will ensure payment of uncompensated care, and protect for the fiscal solvency of New Jersey's hospitals. And we agree.

However, the Hospital Association also wholeheartedly believes that the current definition of uncompensated care, the current financing mechanism of uncompensated care, and the scope of the current Uncompensated Care Trust Fund must be dramatically changed for appropriate incentives to be in place and for desired health care system goals and objectives to be reached.

We envision those goals as the following:

1) Reduce the size of the Uncompensated Care Trust Fund. We can do this by clearly differentiating between bad debt and charity care services.

2) Eliminating the current hospital bed tax for the provision of charity care by broadening the funding base for this societal responsibility, for example, through an employer/employee assessment similar to the State unemployment insurance deduction.

3) Defining the employer/employee contribution for the care to the indigent that provides appropriate incentives to employers that encourage the provision of health care coverage.

4) Administering a newly created Trust Fund as a managed care, enrollment required, insurance company type fund requiring individual charity care claim submissions, a centralized patient data base with required screens for Medicaid eligibility, existing insurance coverage, and potential Homestead Rebate or income tax refunds.

Beyond these objectives, the Hospital Association will urge this Committee to consider the following specific recommendations:

Before discussion of uncompensated care funding is pursued, a clear assessment and definition of the elements of uncompensated care must be determined. Currently, the State's \$754 million worth of uncompensated care is inappropriately defined as comprising 82 percent of patient bad debts and 18 percent of charity care services. The Hospital Association believes that if properly defined, charity care would more realistically represent approximately 75% of the provision of uncompensated care in the State, or \$560 million of the \$750 million currently being provided. The cause of this problem can be simplified into two basic areas:

- 1) The Department of Health's rigid enforcement of extremely detailed charity care regulations, in reality, creates a situation where the majority of charity care services are identified as bad debt services, simply because the hospital is unable to meet the stringent patient documentation requirements. For example: Thousand of patients access our hospital emergency rooms for emergency care during the year and are unprepared or unable to provide the income/expense, asset/liability information required by the regulation. Most of these patients have very little resources or income to pay their bills.

- 2) The regulatory definition of income threshold for patients to qualify for charity care is absurdly low. A family of four, for instance, with a gross income of \$20,100 would not qualify for charity care under the charity care/poverty income guidelines, and again this is defined as gross income. That same family -- a family of four -- with net income of \$14,000 would be disqualified for receiving charity care in New Jersey hospitals. It is not hard to believe that many of these patients end up not paying their hospital bills when accounting for true income.

The charity care threshold is currently defined at 150 percent of the Federal income poverty guidelines, and the Association recommends that the threshold be substantially increased, somewhere in the neighborhood of 200 percent to 300 percent of the Federal income poverty guidelines. Additionally, there must be a catastrophic health care provision defined under future charity care legislation. The catastrophic charity care provision must provide that no individual in New Jersey should be required to pay more than 20 percent of the higher of their annual income or net worth in any one year for medically necessary hospital care.

Currently, the inappropriate definition of the bad debt component of uncompensated care has caused a dramatic overstatement of the actual level of bad debt and a dramatic understatement of the actual charity care services being provided by New Jersey hospitals. Most of the bad debt patients are truly indigent patients and should be qualified for charity care services. This misclassification of uncompensated care patients is of extreme concern to the New Jersey Hospital Association and the hospitals we represent, since the public's perception and misperception including patients, payers, State legislators, and the State's administration, is that the majority of hospitals' uncompensated care is bad debt, that hospitals are simply not doing a good enough job to collect this bad debt, and therefore, hospitals should not be fully reimbursed for their uncompensated care costs.

The importance of appropriately defining uncompensated care, bad debt, and charity care elements of hospital care to the examination of the Uncompensated Care Trust Fund issue cannot be overemphasized. The appropriate definition of charity care services has far-reaching implications well beyond the establishment of an Uncompensated Care Trust Fund. The provision of charity care to New Jerseyans is the basis for our

tax-exempt status for hospitals and the mission that New Jersey's acute care hospitals carry out. The appropriate definition of charity care services is important to maintaining hospital tax-exempt status and to compliance with general accepted accounting principles -- and I provide some definition there, by the industry.

Since bad debts are a cost of doing business or extending credit to hospitals' patients -- and I skipped over to page seven -- this element of a hospital's cost, substantially reduced as a result of the redefinition of charity care, should be directly included in a hospital's rates as an approved element of cost under the State's rate setting system.

The remaining charity care portion of the State's hospital uncompensated care provision should not be included as an element of a hospital's rate set under the State's rate setting system, should not be included as an element of a hospital's billing mechanism, but should be funded more broadly through an employer/employee assessment.

Getting to the question that you've challenged us to provide some information to -- and that's a lot of introductory comments about definition of how the Uncompensated Care Trust Fund works -- specifically, the Trust Fund should be redefined as a fund to provide payment to New Jersey hospitals for the provision of care to the indigent -- that's charity care patients only -- through a broad-based employer assessment.

The fund would be established as an insurance type fund, with hospitals receiving an initial prospectively determined payment and employer/employees paying a prospectively determined assessment. Hospitals would be required to submit directly to the Trust Fund Administrator individual patient bills for charity care services. This would provide the analytical data we all need to understand what patients are being treated in the Fund and whether those patients are appropriately treated as charity care patients.

It will allow for the information for inspection by the State Legislature in this Committee, and by the administration. The Fund Administrator would be able to reconcile the prospectively determined hospital payments and employer assessments with an actual provision of charity care services among New Jersey's hospitals.

In the future, a managed care provision could be built into the administration of the Fund with the administrator developing preferred provider organizations for the provision of managed health care services through physician or patient assignment. Some other possibilities would include:

- * Patient enrollment in the fund, including a one-time application.

- * Maintenance of a centralized data base of patient information, thereby cutting down the administration cost of running this Fund, tremendously, in cutting the paperwork administration in hospitals by probably 50 percent.

- * Patients could be issued identification cards as they move from physician to physician, and from hospital to hospital.

- * Clearance of all charity care patients should be conducted through a centralized insurance coverage data base. These data bases are available, but yet unused, by the administration and by hospitals today that could clearly identify any existing insurance so that we could avoid patients being written off to bad debt and included in uncompensated care, who are insured and should have been properly billed.

- * Screening for medical assistance should also be mandated. We've had some great success in this, this last year, and that is: application to the Department of Treasury against Homestead Rebates and State income taxes which produce \$16 million as an offset against uncompensated care, this last year.

Finally, funding for the provision for hospital charity care services to the indigent should be financed through a payroll assessment, the expense of which should be shared by employers and employees.

The Association believes that employers providing health care coverage should only bear 40 percent of this assessment, and employees should bear the remaining 60 percent. Employers not providing health care insurance would bear the full 100 percent of the assessment with an additional obligation to cover the first 50 percent of employee's first \$1000 of hospital bills, annually.

The Hospital Association estimated the annual payroll assessment to be in the neighborhood of \$150 per employee, based on one percent of the first \$15,000 of earnings. The implementation of a payroll assessment funding mechanism could, however, be phased in over a phase in period. The example we've provided in our last page of presentation exemplifies a four-year phase in period with the payers, who are currently funding uncompensated care, continuing that commitment at a scaled-down percentage over a four-year phase in. This would equal a per employee assessment in year one of about \$40.

Insurers play a major role in both payment for uncompensated care services and potential contributions to the production of uncompensated care -- insurers I say. If the Trust Fund is redefined to cover only the provision of charity care services with only the cost of bad debts being included in a hospital's rates directly, and only that cost in the hospital rate, insurers must be required to recalculate the result in savings and reduce their insurance premiums, coincidentally, with those reductions in the amount of claims being submitted by hospitals. These premium reduction calculations should be reviewed and verified by the Department of Insurance.

Insurers should also, for the first time, be required to identify the elements of their costs, supporting existing

premium levels, to subscribers and the public so we understand what the basis of their insured premiums are, including the breakdown of their claims costs, their insurance company administrative costs, and their profit margins.

Insurers should also be required to meet timely claims processing standards. Insurers, finally, should be required to participate in the statewide data base of insured individuals for hospital inquiries that I mentioned earlier. This would allow hospitals who are a centralized administrator to make sure that all uncompensated care accounts are, appropriately, for the indigent, the poor, and the uninsured.

Again, I appreciate the opportunity to provide these comments to you, and I'll be glad to answer any questions that you have. I think your inspection of this issue is vitally important to New Jersey hospitals, and I appreciate the effort that you're putting forward on this.

ASSEMBLYMAN FELICE: Thank you. Mr. Mowll. Do any of our members have any questions for our speaker here? Yes.

ASSEMBLYWOMAN WRIGHT: Do we just speak, and the mikes will pick us up?

ASSEMBLYMAN FELICE: Yes.

ASSEMBLYWOMAN WRIGHT: Thank you very much, Mr. Mowll, for your comprehensive presentation. It was very helpful also to have a copy. I just had a couple of questions: One was with regard to the use of the employer/employee system for securing the funds for uncompensated care. Since, obviously, this is a document that has had a lot of discussion I wondered if you've discussed any other alternatives, and how you arrived at selecting, because you've opted out for one process? Can you give us any discussion of that so that we-- We know that people discuss it from a variety of perspectives.

MR. MOWLL: Yes. Thank you. I would say that closer to our heart is the broad-based funding mechanism and not the word I've obviously avoided in my entire text, and I won't use it now.

ASSEMBLYWOMAN WRIGHT: You're not running for election so you can use it.

MR. MOWLL: Okay. Well, I understand that part of your challenge, and we certainly appreciate that. The basis for our study, and our recommendations, is what we call a broader-based funding and a societal support for the indigent care. We have recognized that bad debt does not have a place in that, and that bad debt, however, is an expense of a hospital doing business and should be included in its rates, but minimized tremendously.

Broad-based means that currently, 1.2 million patients visit our hospitals as an admission to the hospital overnight and are paying a surcharge of 19.3 percent additional on that bill on each of those admissions. We're saying that through a more broad-based assessment, three million workers in the State of New Jersey with an assessment would be much smaller. It would be funded by a broader base of our residents. That was one method we thought that could be employed. Obviously, a second alternative, I think, and that would be -- that we have talked about -- a tax on areas that lead to ill health: tobacco use, alcohol use; some support for a linkage of health care and usage of those items. Beyond that we have no specific recommendations.

ASSEMBLYWOMAN WRIGHT: Mr. Vice-Chairman, may I ask him a further question?

ASSEMBLYMAN FELICE: Sure.

ASSEMBLYWOMAN WRIGHT: Thank you. My concern is that a tax is a tax, by any other name, whether it's the employee/employer, or whether it's the broad based-income tax, sin tax, or what have you. But thank you. My final question was, can you discuss with us the kind of revenue that would be generated from the employer/employee -- 1 percent is what I think I see you have in here -- and maybe using your chart on page 10, that might help us to focus?

MR. MOWLL: Yes. We calculated, on the bottom of page nine, that the \$150 per employee -- our recommendation that that would be shared by the employees and employers -- would be based on 1 percent of the first \$15,000 of earnings, and that's based on approximately, I think it was, 3.2 million workers in the State of New Jersey. I have to get my calculator and check the math on that again, but the phase in schedule that was presented there was, again, based on the same number of workers but with a diminished participation in financing, with the payers still financing a major portion in year one -- 75 percent.

ASSEMBLYWOMAN WRIGHT: So you're looking at \$560 million taking out the bad debt, and that 1 percent you feel that you could generate that, and then over the four years that you showed us you didn't show an increase when historically we are aware that--

MR. MOWLL: We believe that the initiatives we've presented you with, which are the managed care concept, the screening through an insurance data base-- We've had a very poor track record in screening the eligibility of these patients for Medicaid coverage. It's actually discouraged in the State up until the passage, and, again, I commend you all for putting teeth in that this last go around.

Last June you actually gave some strength to finally getting those who belonged appropriately on the Medicaid rolls, and out of the uncompensated care rolls. I think those reforms will actually lead to a reduction of the charity care level in this State. I think they're just starting to take place now, and we're getting some eligible workers in the hospitals that will assist us in doing that. So, probably-- We've kept the level the same here in the projections, but hopefully it will even come down. And as you are all aware, the actual uncompensated care level included in hospital rates this

go-around, came down dramatically, about 15 percent. We're actually under the cap for the first time. So, it was real good to see that.

ASSEMBLYMAN FELICE: Thank you. Assemblywoman Wright, thank you very much. Anyone else?

ASSEMBLYMAN ROMANO: Just let me say this, Mr. Vice-Chairman. I thank you for the information you've supplied, but I think we all understand that this is your view. This is your hypothesis. There are many so-called hypotheses, because for every argument you make for one way, there's another argument the other way. Now, our problem is going to be with the Committee. I'm sure that with Chairman Colburn and Mr. Felice, we will come up with some sort of recommendation, sooner or later, but, in any event, it's going to be actually like a menu type of program, whether it's a payee or payer, whether it's a universal or State health system.

There are so many things to be considered. Like, when one speaks of a payroll tax: Are we also going to put a payroll tax on those people who have already gotten health benefits, you might say, through very good or excellent health programs, maybe through the negotiated process in contracts, and we'll assume that when they took this on they gave up something in salary -- if we make that assumption -- so now they're going to be paying anyway, even though they have no part into this overall scheme? I just pose that as a possibility. So you're going to have a piece from here, a piece from here, and a piece from here, because right now all the people who I see who are scheduled to testify are involved in the health industry. We don't have here the labor groups, who would have to be considered when one talks about -- I know it's a dirty word, but -- a tax.

Thank you very much. Thank you, Mr. Chairman.

ASSEMBLYMAN FELICE: Thank you Assemblyman Romano. Now, Dr. Colburn.

ASSEMBLYMAN COLBURN: I'd like to clarify this relationship that I believe you referred to -- the Medicaid windfall -- and the way it's being generated, I guess -- justified -- and its relationship, which I think you said was a delicate one, with the Trust Fund. Could you elaborate a little bit on that?

MR. MOWLL: Yes. That's why I added that. It was not in my written comments, but I added that as a preemption to my comments because the Department of Health and the Department of Human Services did a marvelous job in defining a way to bring additional revenues into the State of New Jersey last year, and that was written into the Act, and the State Legislature passed that.

ASSEMBLYMAN COLBURN: It was more than successful.

MR. MOWLL: More than successful. However, the Federal Health Care Financing Administration who oversees the Medicare and Medicaid programs have also tried to have regulation passed that would prohibit these programs; these Medicaid savings, Medicaid donations, or matching programs. Our program has been grandfathered in, for two years. However, it's in the current definition of that Act, and the structure of the Health Care Trust Fund.

Our fear is -- and I've talked to Gerry Goodrich, the Deputy Commission of Health about this at great length -- that if we change any definitions of the Health Care Trust Fund as currently written into law, we're going to jeopardize or give HCFA an opportunity to say, "Wait a minute you've changed your program. It's a different program, and, therefore, it's no longer qualified for these funds, to the State of New Jersey." That's why I wanted to make that my very first comment.

ASSEMBLYMAN COLBURN: So those definitions have to be carefully made.

MR. MOWLL: I think so, and I think you'll hear from the Department of Health, hopefully, or can get some additional

guidance. I understand that Saul Kilstein at the Department of Human Service, Director of Medicaid, is most knowledgeable about that. He handled the application process and probably should testify before this Committee as well.

ASSEMBLYMAN COLBURN: Okay.

ASSEMBLYMAN FELICE: Thank you. Are there any other questions?

ASSEMBLYMAN COLBURN: I have another one.

ASSEMBLYMAN FELICE: Go ahead.

ASSEMBLYMAN COLBURN: I guess I was a little confused about what group you were proposing would be in the managed care category. Would they be the currently uninsured? Is that what you're talking about?

MR. MOWLL: Yes. It would be patients -- not bad debt patients -- who after an application, we've screened them for income, and they are truly charity care. We would manage their access to the system and therefore-- It's been argued that these patients have the best health insurance program in the State, because there is no current disincentives.

ASSEMBLYMAN COLBURN: You mean the uncompensated care group right now?

MR. MOWLL: Yes. Right. There's no disincentives to not get MRIs, CAT scans, and the best care that we have. We felt that managed care -- oversight of that care provision could -- and again, answering the previous question -- actually diminish the level of charity care services over the next few years.

ASSEMBLYMAN COLBURN: When I met with some of the groups, more or less privately or in a preliminary way, before some of these hearings I did suggest that managed care ought to be an option to the people that are going to get the basic coverage that we've been talking about. Now, HIP had one idea, which would be their kind. How would yours differ from the HIP organization, or don't you know enough about them to say?

MR. MOWLL: I can't comment on their product. Certainly the philosophy of how they manage their patients is a good one, and it certainly has application here, I think. There are some provisions in the Health Care Cost Reduction Act that talks about the Garden State Health Plan--

ASSEMBLYMAN COLBURN: Yes, which is already existing for Medicaid.

MR. MOWLL: Right -- and trying to get more of these patients enrolled in those plans. But it's a slow process. Our recommendation is just to enroll them immediately. Let's get everyone in. Let's have an assignment of these patients to--

ASSEMBLYMAN COLBURN: And you'd have to create this PPO though.

MR. MOWLL: Yes, you would have to. Or it could be the existing HMOs and PPOs in the State and on a contracted basis.

ASSEMBLYMAN COLBURN: Okay. One other thing I wanted to ask you. I think you spoke of getting more data as to the cost of administration and also the cost of providing services by the private insurers, and make that public?

MR. MOWLL: Yes.

ASSEMBLYMAN COLBURN: Is there a problem there with having them divulge what might be called trade secrets or anything?

MR. MOWLL: I don't know that. But I know that in the financial statement from insurers there is some disclosure of their percent of profits, obviously, on the financial statements. Their administrative cost is a little harder to determine. The question I think-- And I'm paying \$1800 out of my pocket for insurance coverage, as well, every year in an HMO plan. The question I want answered, and I'm sure we all want answered is: How much of our health insurance premiums are going for the cost of care, how much is going for profit

margins, and how much is going for administrative costs? That's not clearly disclosed, I don't think, today. It may be, through financial statements, and someone who has an accounting degree to work through it, but that's the point we're trying to get out.

ASSEMBLYMAN COLBURN: Okay.

ASSEMBLYMAN ROMANO: Mr. Chairman, if you'll allow me?

ASSEMBLYMAN FELICE: Yes, Assemblyman?

ASSEMBLYMAN ROMANO: When they talk about the PPO-- The PPO has been the one, traditionally, that has come the closest to what they might call traditional health plans, with having choice of doctors, etc., but in the HMO -- we had a speaker here before -- the Rutgers Plan is one of the finest HMOs. They have about 16 to 17 HMOs, and they have PPO and there are a few other acronyms, that elude me right now. (laughter) It's what the person wants.

You recall at the close of the session where I put forth that resolution which all of my colleagues voted for, that was to provide an open enrollment period for those State workers that had been scheduled to be fired over the summer; where, when they were covered with the State paying it, was one thing to have a traditional health plan. Perhaps when they saw that they would no longer be having it paid by the State, and they would have to pay for it under COBRA, they might not then want the traditional plan but to move over to an HMO, in which the cost of premium was not so different, but it allowed for the deductible less \$1 pay, etc., etc.

By the way, I did contact the Division of Pensions, and some people did take advantage of that, because when not working, that same premium that they might have paid for a traditional plan gave them more under an HMO. This is the whole gamut. When one reviews the HMOs and the HIPs and the PIPs and the PPOs, you have to look at what's best for you and your family.

ASSEMBLYMAN FELICE: Thank you, Assemblyman.
Assemblyman, do you have a question?

ASSEMBLYMAN SMITH: Yes. How does your employer/employee assessment differ from the existing payroll tax proposal that's been kicked around for at least the past year that I know of, and possibly longer?

MR. MOWLL: It should be fairly close. I think the only difference is that we don't-- I think there was a provision there -- a pay or play provision or something -- that if the employer did not provide health care that they would pay a \$1000 penalty or assessment, if I recall correctly. We haven't proposed that here but we do propose that they pick up a share of employees' health expenses, if they don't provide the health insurance.

ASSEMBLYMAN SMITH: It starts out at about 1 percent and then it graduates up to about 4 percent to 5 percent?

MR. MOWLL: Our proposal does not, and I'm not familiar with the graduation scale on that previous proposal.

ASSEMBLYMAN FELICE: Thank you very much, Mr. Mowll. For our next speaker we have representatives from the Department of Health.

Hello.

KATHLEEN BRENNAN: Good afternoon. I'm Kathleen Brennan. I'm the Director of the Health Care for the Uninsured program in which I am responsible for the administration of the current Health Care Trust Fund. I will be mainly discussing the report that the Department of Health recently sent to all of you regarding the 1991 performance of the Health Care Trust Fund, and the work that we will be doing over the next six months until the Trust Fund expires.

First, as Mr. Mowll indicated earlier today, we are very, very pleased to be able to say that for the first time since 1980, uncompensated care has gone down -- and gone down substantially. The difference between the 1991 projection of

uncompensated care and the 1992 figure, is approximately 15 percent, approximately \$85 million which, given increases in health care costs, shows that the efforts undertaken by the Legislature, by the administration, and by the hospitals particularly, have had an impact on the continued expansion of uncompensated care. I can also say that we have had no increase or no problem with people reporting that their access has been denied to hospitals. So, this is a real increase in collections, a real increase in going after insurance, a real increase in payments, rather than an artificial decrease due to people not being able to get the care that they need at the hospitals.

One of our primary initiatives this year involved the Department of Treasury, Division of Taxation SOIL system. And, to update what Chuck said earlier, it's no longer \$16 million that has been collected from people whose homestead rebates and State tax refunds have been withheld by the Department of Treasury. It's now up to \$17.5 million. So this process has been, for all the bumps last summer, very successful in recovering a significant amount of money for the benefit of the payers of hospital care.

We have done a great deal of research work this year, as directed by the Legislature last year. There are three research projects that have currently been conducted; the results of which have been provided to you. First, we've done an update on the number of New Jerseyans who are uninsured. That currently is projected at 782 million. Approximately 10.2 percent of the population of New Jersey does not have health insurance. In 1986 we did a similar study, and the rate of increase-- Although New Jersey is still among the states with the highest insured percentage, the number of people who have lost their insurance between 1986 and 1989 has been well above the national average. This is something we've been seeing

anecdotally, but we now have data showing that we are losing insurance coverage and this is, and continues to be, a major concern.

For the first time, this year we are able to give you information, not just about the uninsured in New Jersey. We have spent significant time over the last year looking at the bad debt population -- not just the uninsured, the people who are actually using bad debt services. There are two studies that have been done, one which actually went out to hospitals, looked at their files, tried to determine why debts were unpaid. Were the people who were in the bad debt pool-- Were they insured? Were they uninsured? Why wasn't the debt paid? The results of that are in your study. I will be glad to answer any questions about that.

Also, Chapter 187 requires hospitals every quarter, to send us aggregate data regarding all the people who they've written off to bad debt during that quarter. We have compiled the first quarter's results. We are collecting the second quarter's. It shows a not very surprising pattern. People who tended to be uninsured, tended to be young, tended to have small balance accounts. One of the most surprising findings of this study was that 66 percent of the accounts that are uncompensated care are under \$500, but they come out to only 18 percent of the uncompensated care dollars. Only 10 percent of the accounts that are written off are for over \$2000, but they represent 66 percent of the Uncompensated Care Trust Fund. This tells us something fairly significant for future policy-making, as far as where we need to look in order to make the maximum impact on covering bills. It will also give us some information so that we can look at other insurance programs, look at other options, and you will continue to receive information on this as we go on.

We have two -- actually three -- programs in the works right now. We have a study which was required under Chapter

187, to look at demographic data regarding the bad debt component of the Trust Fund. We are about to award a contract for this, and we anticipate having this information to you by May 1, 1992. We are also just starting month three of a hospital billing and collection demonstration project. The purpose of this project is to see if innovative ways to collect hospital bills can be devised by outside vendors. We are just starting to aggregate the data and we will have a report to you on the first three months of this data, in the next couple of weeks.

Finally, we have another initiative which is in the RFP stage now, which requires hospitals, after they have done everything that they think reasonable to do on a bad debt account, to provide information on that account to the State. Let us set up a system of regional collection agencies, give it to those collection agencies, and see if an additional amount can be collected through that. We would anticipate that that would be beginning sometime in the late spring. We are currently out to bid with collection agencies that are looking to provide this service to us.

My final comments will be on the Federal Disproportionate Share Law, the process by which the Federal government matches the money going through the Trust Fund into the hospitals, and therefore creates additional revenue to the State of New Jersey. Through the National Governors' Association, Counsel to the NGA is looking into the issue of the extent to which the Trust Fund can be changed without jeopardizing those amounts. That information should also be forthcoming. We obviously do not want to act precipitately if that means that we're jeopardizing a significant amount of money coming into the State, but it is not clear at this point, the extent to which all changes would be forbidden by the Federal government.

I'd be glad to answer any questions that you have.

ASSEMBLYMAN FELICE: Thank you, Ms. Brennan. Are there any members of the panel that would like to ask Ms. Brennan questions?

ASSEMBLYMAN ROMANO: If I may?

ASSEMBLYMAN FELICE: Yes.

ASSEMBLYMAN ROMANO: I think what I'm hearing here -- and I'm happy to hear it, because I did vote for the Health Care Cost Reduction Act, and I think there are a lot of good things in that Act. And as we have our hearings, those areas that give us problems I hope that we will tend to, but you've pointed up a lot of the good points of that Act.

Thank you very much, Ms. Brennan.

ASSEMBLYMAN FELICE: Dr. Colburn? Thank you Assemblyman.

ASSEMBLYMAN COLBURN: Has it ever been considered to charge interest on any of these unpaid bills? I suppose it might be an act of--

MS. BRENNAN: Well, Chapter 187 does require insurance companies that don't pay within 60 days, to pay interest. There is nothing precluding a hospital from charging interest on its unpaid bills, providing that the interest rate is disclosed before admission and the patient agrees to it. Some hospitals I know, do have patients sign these types of agreements when they come in. We simply require that if they do collect interest payments, that they offset them against their outside collection costs.

ASSEMBLYMAN COLBURN: The other thing I was wondering was, is there any thought or any desirability, or any lack of desirability, to having the State be the last collector of these bills; kind of add it to the Homestead Rebate type of collection and send as bills from the State of New Jersey? Would that do anything?

MS. BRENNAN: Well, that is the process that we currently have out to bid, that after the hospital has done

everything-- They've gone through their collection agency, they've sent it to their attorneys, they've decided that this bill is completely uncollectible, that they send it to the State for centralized activity matching against computer data bases, to maybe catch some insurance that the hospital missed. We are actively going forward with that. There has been a regulation proposed to require hospitals to give us this information after they have finished with the account.

ASSEMBLYMAN COLBURN: I may have misunderstood. I thought this RFP included private collections agencies, or was that not so?

MS. BRENNAN: Well, the regulation requires hospitals to send it to the State, and the State not having significant collection experience or staffing, the State is planning on contracting with private collection agencies to do this work.

ASSEMBLYMAN COLBURN: I see. Well when they went to collect, would it be pretty clear this was being acted upon in the name of the State, and would the State seal be on the-- You know, would it look like Governor Jim was sending this out?

MS. BRENNAN: That has not been decided yet. What would you counsel?

ASSEMBLYMAN COLBURN: I shouldn't have said that. Well, it just seemed to me that if the person knew the State of New Jersey was after them, it might carry more weight with them than if it was a private person. That was the reason I asked the question. Really.

ASSEMBLYMAN FELICE: Thank you, Dr. Colburn.

Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Ms. Brennan, if there's been a 15 percent drop in uncompensated care costs, how come the hospital rate only went down by six-tenths of a percent, from 19.7 percent to 19.1 percent?

MS. BRENNAN: The gross amount changed from-- The amount of uncompensated care in 1991-- What we needed to

collect was \$839 million. In 1992 it's \$754 million. There are a couple of reasons why. The 19.1 is based on the amount of hospital revenues, and there have been increases in hospital revenues. So, the 19.7 amount that we used last year generated the \$839 million, but now that we have new hospital revenues, you can't compare the two. It's on a different base.

ASSEMBLYMAN MIKULAK: Okay, but the cost went down by 15 percent, which, I don't doubt that.

MS. BRENNAN: Yes. The dollars went down by 15 percent.

ASSEMBLYMAN MIKULAK: But the rate didn't, and I can't ask you to speak for the Rate Setting Commission either, but I mean the rate didn't decrease by anything near 15 percent.

MS. BRENNAN: No, and that is because they're on two different bases.

ASSEMBLYMAN MIKULAK: Thank you.

ASSEMBLYMAN FELICE: I'm going to interject a question in-between here. The last meeting that we had with the Commissioner, the facts that were given to us were the fact that of the uncompensated care, 82 percent of that uncompensated care was bad debt and only 18 percent was charity.

MS. BRENNAN: That is correct.

ASSEMBLYMAN FELICE: Okay. I just wanted to know if that has changed any.

Yes, Barbara?

ASSEMBLYWOMAN WRIGHT: I just want to follow up the comment you just made; that is, the 18 percent of charity care is based on the present definitions that some people feel need further attention, so that it is under those existing definitions, possibly some of the bad debt is also charity care. It's just that our definitions are not teasing that out.

MS. BRENNAN: Well, I would say that it's less the definition than we know that there's a large number of people who would be eligible for charity care if they applied.

ASSEMBLYWOMAN WRIGHT: You just answered my question.

MS. BRENNAN: Okay.

ASSEMBLYWOMAN WRIGHT: Mine were just a couple of technical questions. Since you gave us the data, I just wanted to follow up to be sure I understood them.

When you talked about the bad debt population, you talked about the 66 percent that were under \$500? Is that how I understood it?

MS. BRENNAN: Actually I misspoke. It's 73 percent of the accounts were under \$500 and 18 percent of the dollars.

ASSEMBLYWOMAN WRIGHT: Eighteen? That was what I wanted to get at. And, of the write-offs that were over \$2000, that made up 66 percent of the--

MS. BRENNAN: Sixty-six percent of the dollars and only 10 percent of the accounts.

ASSEMBLYWOMAN WRIGHT: The dollars, though-- Okay, I just wanted to be sure that they were over \$2000.

Thank you, Mr. Chairman.

ASSEMBLYMAN FELICE: There's no one else? (no response) Thank you very much Ms. Brennan. We appreciate it very much.

MS. BRENNAN: Thank you.

ASSEMBLYMAN FELICE: At this time I'm going to call the next speaker, Assemblywoman Charlotte Vandervalk.

ASSEMBLYWOMAN CHARLOTTE VANDERVALK: Thank you very much. Good afternoon. In the interest of keeping it as brief as possible, I will limit my remarks to two points.

One is very, very brief. It just refers to the fact that last June the Governor signed the Health Care Cost Reduction Act, and in that Act it requires that the Health Care Trust Fund Advisory Council be established. That was never established, and I'm really shocked by that because of the enormity of the problem. I would liked to have had, certainly, a full year of people, experts, dealing with this crisis for

the year that was remaining, since we all know that the act has to be dealt with by this June when it sunsets. So, I just congratulate you, here on the Committee, for at least starting to do what should have been done for a year already. I think this is a very critical problem. I think New Jersey has always been a leader in health care, and I think we can continue with that.

My second point to you today is that there's been a lot of discussion over the years as to what really constitutes bad debt, and do the hospitals really do their collections -- a proper collection procedure for bad debts? There were obligations under the law that were imposed on the hospitals. They had to send out so many letters, so many phone calls, and so forth. Again, there's always a question when you're mandated to do something, whether you truly do it in the full spirit or if you just go through the motions. I think when we can provide incentives, we're always better off. We always get better results.

I have a bill in that would talk to you about the incentives that we need in this system. With those incentives, the hospitals would do their own collection procedures their own way, and when they're finished with their methods they would submit the accounts to the State -- to the Trust Fund. The Trust Fund would then do a follow-up through a system of collection agencies. Now, if the collection agencies determine that these accounts are truly uncollectible, then, under my bill, the hospitals would be reimbursed fully for those truly uncollectible accounts. Conversely, if money is collected by the collection agencies, that money goes into the Trust Fund. It does not go back to the hospitals because that money was collected. It was collectible. The hospital really didn't do its job.

Now, with that system, you're providing an incentive. Every hospital will be motivated to do its best collection

effort; likewise with the State. That collection agency that works for the State, by the way, will not be paid on a contractual basis such as the Department is doing right now. The fallacy of that is there's no incentive. If you hire a collection agency like it's done through the private sector, you hire them on a percentage basis; on a commission, if you will. Under that, they're stimulated. They have the incentive -- the motivation to do a thorough collection process, so everyone is motivated. You will then determine what is truly collectible, and what is truly uncompensated care.

I really can't see any downside to it because there will be no cost to the Trust Fund because of the way that you'll be hiring the collection agencies. Incidentally, this will provide-- In addition to the prime goal of motivating the collections, in addition to that, it will provide some other benefits to the system. It will, first of all, end the ongoing argument of what is bad debt. Is it being collected, and so forth. Secondly it will provide an automatic audit on each account. So it's going to simplify the work for the hospitals, and also it will provide -- once it gets phased in -- a rather, I don't want to say a rapid turnaround, but certainly a more rapid turnaround than what we have under the present system. Because what the hospitals are dealing with now, they are years waiting for their accounts to be paid to them through the Fund, and that's something that just is not in anyone's best interest.

So, I'm very excited about this as a possibility. I think it's driven by the American principles. I will stop, but I would like to answer any questions if there are any.

ASSEMBLYMAN FELICE: Thank you, Assemblywoman. Does anyone have any questions? We have a copy of your bill.

ASSEMBLYMAN SMITH: I haven't seen your bill yet. I think it was just Faxed before we left the office. Does your bill contain the things that you're talking about -- the incentives for the collection agencies?

ASSEMBLYWOMAN VANDERVALK: Yes. The language is such that it may not jump off the page at you, but I think the statement does explain what I have just said, and that is certainly the intent. I think this is the direction that we really should go for in the future. There's no downside.

ASSEMBLYMAN SMITH: I agree with you.

ASSEMBLYMAN FELICE: Thank you, Assemblyman Smith. Anyone else? (negative response).

Thank you very much, Assemblywoman Charlotte Vandervalk.

At this time, Bruce Coe, the President of New Jersey Business and Industry Association.

B R U C E G. C O E: Thank you, Mr. Chairman, Committee members. I apologize for being late, but on the good news side, we had a Transportation Trust Fund Authority meeting today, and we authorized the sale of \$275 million of bonds which will occur on March 17 which will be part of our ability to spend \$1.4 billion on much needed infrastructure projects and will probably be sold -- and this is a guess -- at an interest cost of something in the area of 5 1/2 percent which is partly because it's got AA ratings from both Moody's and Standard and Poor's, without any State guarantee whatsoever.

ASSEMBLYMAN FELICE: We forgive you then for being late.

MR. COE: I thank you.

In terms of who is the Business and Industry Association, most of you know, but we are an association of businesses. We now have over 13,400 members, including a net increase of 57, year-to-date which makes us more than twice as large as the California Chamber of Commerce, which is the second largest business association in any state in America. So, something's thriving in New Jersey -- our membership -- despite the economic hard times.

In terms of health care issues, we've been into these heavily for the last three years, partly because when we surveyed our members in each of the last three years, their number one problem has not been regulations, has not been that awful 2.8 billion tax package, but rather, health care costs. So, we now have two full-time staff people; we have a committee of 45 members, and they've been dwelling in-depth over all aspects of health care. And as one part of a conclusion, I would urge-- One, I'm delighted that this Committee will be in being and will attack health care on a comprehensive basis. That's the first major point. We've learned that health care is not something where you can squeeze one part of the balloon, because if you do, it's going to pop out over there. So when you approach health care concerns and health care issues, you really have to have a very comprehensive approach, or you're going to get in trouble.

The second major point which I would urge the Committee to focus on is the point: Does regulation work? A number of states in America have regulation; far more have no regulation. The trend in recent years has been to deregulate. In recent years, both Massachusetts, presently, and California some years ago, have chosen to deregulate. The follow-up to that is if you conclude that regulation is better -- and we're studying that very point-- By the way, we don't have a conclusion. We're studying all the cost data on regulated versus nonregulated states. But if you do conclude that you want to regulate it, the follow-up question is: Are we structured to do that in the right way?

Right now we have three Commissions: We have a Planning Commission, we have a Rate Setting Commission, and a third, the Health Care Administration Board. We're all volunteers. We all have varying degrees of qualifications for the jobs we're doing, which is a nice way of saying that maybe I'm not as qualified as I should be. And what I've seen today

would lead me to conclude that that's not the right setup to regulate health care. Now, what might be better? The only model I know of in New Jersey is the former BPU that regulates utilities. It has a full-time professional staff, and moreover, it has full-time paid professional commissioners. I'm not sure where we're going to come out on regulation versus lack of regulation. My present guess -- and it's about 51 to 49 -- is we may conclude that deregulation is better.

In turning in my testimony itself-- Do you have copies of it?

ASSEMBLYMAN FELICE: Yes.

MR. COE: Good. There's one typo. When we were putting this together, it's on the first page; I guess it's number page 2, not the cover page. In the second paragraph, two-thirds of the way down, it refers in some unrelated manner to an onerous tax which expires on June 30, 1992. The next sentence points out that that's the 19.1 percent tax on hospital bills which we described as the worst tax in New Jersey. Now here, where every effort nationally is being made to encourage small companies to provide health care for their employees, we in New Jersey, say if you do it, we'll punish you. We'll put a 19.1 percent tax, with full knowledge that may be used to subsidize the health care competitors. So, if anything's wrong, that's wrong.

Everybody gets puzzled about why their premium-- I keep asking my treasurer, "Why does my premium go up by 25 percent, when the hospitals tell me their costs are going up by 8 percent?" I think we really need to focus on that. We have a system in New Jersey today wherein Medicare backed out in '89 of paying uncompensated care. They said, "We can't afford that." Medicare since then has backed out of even paying their bills, and as you all know, this year there will be a \$450 million shortfall. That means Medicare is paying \$.85 on the \$1.00. The hospitals are held harmless, however, and that that

tax gets transferred to a group I would call, "the dummies." I'm one of the dummies. Medicare pays 42 percent of hospital bills in New Jersey.

That brings us to Medicaid. The Governor's initial budget, which is not the one we've all seen, but the one they had contemplated doing before they realized the full value of both Medicaid windfalls and Pension fund windfalls, contemplated that Medicaid, too, should do this; that there should be a \$216 million Medicaid shortfall. Now with the windfalls, that shortfall has been reduced, as I understand it, to \$48 million. For the first time, we'll have a Medicaid shortfall. Medicaid pays 10 percent of the hospital bills. So, here we have Federal government at 42 percent, State and Federal an additional 10 percent, both saying, "We don't have enough money to cover the costs of our existing obligations." I mean this, by the way, is where universal health care would end up. These are the people that we want to take care of everything, and they can't even afford to take care of what they're doing now.

Which brings us to uncompensated care, which is 11 percent of all hospital bills. So, 42 for Medicare, 10 for Medicaid -- 52, 11 for uncomp care -- 63. Then we come to Blue Cross/Blue Shield which, understandably, is the insurer of last resort and therefore, gets their discount on hospital bills. Although the hospitals are held harmless, their individuals are about 7 percent of all hospital bills. So, now we're up to 70 percent of all hospital payers who have concluded they can't pay their bills, or they need a discount. That gets shifted to the rest of us. So, if my hospital bills here, at Valley Hospital for my employees were to go up by 8 percent, my health insurance premium is going to go up by 24 percent, primarily because of the cost shift. We should really be clear on that.

Now the cost shift, and I mentioned that I was one of the dummies-- Now the smarties are signing up with the

so-called managed care providers, and I applaud them and I think managed care is part of the future -- which always will lead Chairman Colburn to ask me to define what I mean by "managed care" -- but as part of that being outcome-oriented, quality provider-oriented, it's also a very price- and maybe discount-oriented.

So, right now, today, you have major providers such as U.S. Healthcare which insures about one million people in New Jersey, and you have Blue Cross/Blue Shield with their managed care, you have PruCare, and others. What they're doing is negotiating discounts. I know of a specific hospital who recently agreed to a 25 percent discount for U.S. Healthcare. I'm under the impression that in Blue Cross/Blue Shield's survey of hospitals, of the 83, that 73 responded indicating, "Yup, maybe we'll give a discount, too." Now these are what I call the smarties. They say, "We don't want to pay all this cost shift, and we can control a lot of volume so we'll get a discount."

Of course, that discount means that I'm getting stuck even harder. So that's the present system. That's a disastrous system. You have a Hospital Rate Setting Commission saying, "This is what the rates should be." Right? Nobody pays it. I mean, there's a lot of confusion about DRG versus actual cost, but that's because of the two billing system, which is stupid. The other big issue is Medicare doesn't care what the Commission says: They're going to set their own rates. So you've got a very weird market that's not working well and really needs to be addressed.

On a more positive standpoint, as I indicated in my testimony on page 2, there were some good initiatives from the Health Care Cost Reduction Act of '91 and I bulleted them on that second page:

Medicaid has been expanded to 185 percent of the poverty level for pregnant women and infants up to one year of age.

Forty-eight hospitals now have on-site Medicaid-eligibility workers to allow hospital based enrollment of uninsured Medicaid-eligible patients.

That, by the way, is a huge number; that's not a little number. There's a ton of people -- and if Congressman Payne were here, he would tell you -- who are street smart; who don't want to fill out a 16-page form in some governmental office because they can walk into any hospital they want, any time they want, and be taken care of.

The best story about why it wasn't working was actually told to me by Kevin Halpern of Cooper Hospital in Camden who once argued with Freeholder/Director Rob Andrews, now Congressman Rob Andrews, "Please, get somebody in my hospital. You people are the only ones that qualify for Medicaid. I can't get them to go 10 blocks to your office. You've got to get them here." He couldn't get them there. So, that's one piece of very good news; that we're now going to have workers in the hospitals.

The next point relates to the insurers being required to offer an affordable health program emphasizing preventive services and costing approximately \$1500 per year.

The next one is the evening and weekend hours at nine community health centers. That's progress.

The next one is the partnership between hospitals and community-based providers through various initiatives to provide less costly primary care at the center.

On page three now, and the final point is HealthStart Plus which will provide access to medical care for pregnant women and children up to age one year for families with incomes up to 300 percent of the Federal poverty level.

There was talk earlier about uncompensated care, and what's bad debt and what's charity care? Yes, the charity care definition should be modified. But to me, one of the most striking things that has been learned recently results from the

first comprehensive study of all 83 acute care hospitals. This is the report that I think you have from Commissioner Dunston on the New Jersey Health Care Trust Fund -- a report provided in February to the Governor and the Legislature.

When you go through those findings, starting at the bottom of the page three, you find out that 64 percent of the uncompensated care records had no employment information on the person whatsoever; whether they were employed-- Didn't know. Sixty percent of the bad debt had no employment information. Turning to the top of page four: For self-pay accounts of patients under 18 years of age, 60 percent of the records had no health care coverage information on the child's parents.

Next point: For self-pay accounts of married persons, 67 percent -- two-thirds -- of the records had no health care coverage information on the spouse.

Next point: Forty-seven percent of the clients paid zero towards their bill, whether inpatient or outpatient.

The next point is remarkable: Seventy-three percent of the records were for balances under \$500. In addition, 17 percent of the records were for balances between \$501 and \$2000.

Turning to collections which is one of your focuses today: Commissioner Dunston said in that report, that paragraph on page four -- which I won't read in its entirety -- but as she says, "There are still too many nonemergency situations in which the hospitals fail to obtain insurance and employment information." -- two basic elements for a successful collection effort.

We also applaud the Department and State government's effort to help the acute care hospitals improve their collection process. As I think you know, they're currently running a program through May of this year, working with six vendors and 14 hospitals, studying how innovative collection techniques can reduce the amount of bad debt. The Department plans, this month, to start working with the collection

agencies and attorneys to attempt to collect bills that hospitals have determined to be uncollectible. I think they're going to wait until they're one year old, which may be a little too long, because one year later it may be hard to find them. During calendar year 1991, the first full year of the SOIL program, \$17 million or 4.3 percent of bad debt was recovered from homestead rebates and State income tax refunds. That's progress.

I think that probably one of the greatest incentives for hospitals to work with alternative primary care providers, to do a better job of collecting their own bills, will be the expiration on June 30 of this year -- that tax that I described as the worst tax in New Jersey -- the 19.1 percent tax. That clearly is an issue that you'll be concerned about, and it's an issue that's going to have to be resolved one way or the other. I predict short-term it's going to be resolved by hospitals doing a dramatically better job of qualifying people for either Medicaid or charity care if they're really poor, or figuring out how to collect their bills.

I didn't have the numbers in here, but they do have income information on the bad debt group. You recall there's a significant number that earned more than 500 percent of defined poverty income and another significant percent that earned between 300 percent and 500 percent. In terms of comprehensive reform, I think that's clearly important. I know you're working on it. It obviously includes incorporation of managed care approaches in both public and private plans. I'm delighted that the State is finally getting around to taking its 600,000 Medicaid clients and contemplating putting them all into a managed care environment. That's good.

Medical malpractice reform has to happen in New Jersey. That's a critically important cost area.

The Medicare cost shift is something we have to come to grips with. Right now it's a wonderful thing for the

Federal government to conclude, "Well, look, we don't get any wrath whatsoever from Medicare recipients or anybody else in New Jersey, so why don't we short fund it even more? It will help reduce the Federal deficit. Nobody in New Jersey's complaining about it. George Bush hasn't heard about it. Bill Bradley hasn't heard about it. And nobody's doing anything about it." And the way Mr. Berman is trying to control budgets, it's likely to expect that that \$450 million will be dramatically greater in each of the succeeding years.

The bill that we're most interested in is the one that will provide for small group reform. And I know you, Mr. Chairman, Assemblyman Felice, and Senator Bassano, recognize that need too and are involved with legislation to address it. If we don't address it by making small group insurance more affordable, we're going to see a continuation of the trend that I referred to on the bottom of pages five and six, wherein the number of our members providing health care is declining, as a percentage of our total membership. Occasionally I've discussed with my Board, should I hold forums for small companies that have relatively modestly paid employees and explain to them why they should drop their hospital insurance? You know, give their employees a \$500 a year raise and pay me a \$100 fee per company for the idea, and save themselves an enormous amount of premium, knowing full well that the present system will provide hospital care for their employees. We always conclude that, "Bruce, that's a stupid idea and don't do things like that. Reform the system."

That really concludes the primary comments I wanted to make and I thank you for the chance to be with you here today.

ASSEMBLYMAN FELICE: Thank you, Mr. Coe.

Would any members like to ask any questions?
(negative response)

Thank you very much. You've been very informative, and we'll be working with you.

MR. COE: Thank you.

ASSEMBLYWOMAN WRIGHT: I'd like to ask--

ASSEMBLYMAN FELICE: Yes. I'm sorry.

ASSEMBLYWOMAN WRIGHT: Mr. Coe, you directed your remarks towards the bare bones policies for insurance reform. I didn't hear you mention anything about how you would, in fact, fund the charity care which I think we all believe will always be there to some degree or another. It may be a much smaller portion than we're presently funding under the existing structure of 19 percent, but I wondered if you had any suggestions, or if the NJBIA has a position on how charity care should be funded?

MR. COE: Yes. What I would urge you to-- The existing charity care definition is stupid in the sense if you have assets of more than a handful amount, you're disqualified regardless of income and regardless of the size of the bill. So one, I would urge you to refine the definition of charity care, which would have the effect of broadening the eligibility for poor income people with modest assets. I mean, I love people that are working. Maybe it's sad that they're working at \$18,000 a year or \$15,000 a year, but that's terrific, and they need health care, and the system must address their needs.

In terms of how would one fund charity care, I could give you quick answers. We have a \$800 million Medicaid windfall in the current fiscal year. We contemplate a \$470 million Medicaid windfall in the year beginning July 1, and the Governor's budget does not use any of that money to fund either charity care or uncompensated care. So, there's some dollars that seem to relate, conceptually at least, in terms of what they should be used for.

ASSEMBLYWOMAN WRIGHT: But the BIA doesn't have a position for continuing the funding of charity care in any continuous way. You're not happy with the 19.1 percent, but at this point you're not suggesting an alternative.

MR. COE: The only consensus I could get is: One, we ought to do a dramatically better job of improving the collection methods. And we should require -- and hospitals will tell you they try, "But we all want that business where, if you put it in this pile, you get 100 cents of a dollar--" There is a consensus that the hospital tax is the worst way to fund it, which then means, if you want to come up with a broad-based tax to fund charity care, that's your question: What would that be? There is no consensus on whether that should be through an income tax, whether that should be through taking moneys out of other State expenditures and applying them to this, such as some of the Medicaid windfall, whether there should be a payroll tax-- I mean, we do have a payroll tax for Social Security, for unemployment insurance, for temporary disability, but there's enormous opposition, particularly among small business to implementing a payroll tax in the current economy. So, I have no consensus for you in terms of what tax would be better than what's clearly the worst tax.

ASSEMBLYWOMAN WRIGHT: That's helpful.

May I ask one other question, Mr. Chairman?

ASSEMBLYMAN FELICE: Sure.

ASSEMBLYWOMAN WRIGHT: Do you see any value that the surcharge has offered to us as a State in terms of delivery of our health care system? Do you think there's any benefit to the total system?

MR. COE: No. We have a unique system and if you could get to a guy named Jeff Merrill, who teaches at Columbia, to come testify, he has a speech about health care systems in the free world. We, in the United States, have the only one created by the providers. I'm not anti providers, but it was not created with a public purpose of working on prevention. I mean, isn't weird you have Medicaid dollars that say, not one penny for prenatal care, but if that underweight baby weighs a pound-and-a-half, you can spend \$200,000 trying to keep that

poor child alive? It's a weird system, and it really needs comprehensive reform. I would encourage you, as we do, to explore how to tilt that whole system more towards prevention.

ASSEMBLYWOMAN WRIGHT: Is there some sensitivity then, that prevention of illness and promotion of health might be more cost-effective in the long run?

MR. COE: Absolutely. In fact, there's a Dr. Louria of the University of Medicine, who you apparently know of, who Chairs their Department of Prevention -- I'm not using the right names -- Preventive Medicine. I believe he has caused a bill to be introduced in the Legislature, modeled after, you know, the thirteen basic preventive things that every citizen should have. He firmly believes that that could be done at a cost of perhaps not much more than \$200 per year for the entire preventive program. We believe in that type of approach.

ASSEMBLYWOMAN WRIGHT: In your continued discussions of this topic--

MR. COE: It's humane. Not only is it cost effective, it's humane. It's common sense.

ASSEMBLYWOMAN WRIGHT: We need all of the input that you can give us.

MR. COE: Yes, and we are working-- I should say we are working with a number of people, including Blue Cross, towards defining policies that might have the preventive package as well as at least some basic health insurance -- bare bones is an awful word, but something more affordable, certainly providing for some catastrophic coverage -- and we plan to work with them marketing it. We won't make one penny doing it, but we will promote the best small business programs to our members, aggressively.

ASSEMBLYWOMAN WRIGHT: And you'd expect them to have health promotion, illness prevention aspects in them?

MR. COE: Absolutely.

ASSEMBLYWOMAN WRIGHT: Thank you very much.

MR. COE: Thank you.

ASSEMBLYMAN FELICE: No other members? (no response)

Thank you, Mr. Coe.

At this time, our next speaker will be Mr. James Morford, Vice-President of Government Relations, New Jersey State Chamber of Commerce.

J A M E S C. M O R F O R D: Good afternoon. Thank you, Mr. Vice-Chairman, Mr. Chairman. Members of the Assembly Health and Human Services Committee: I am James Morford, Vice-President for Government Relations, New Jersey State Chamber of Commerce. We are pleased to have the opportunity to address this public hearing today.

The New Jersey State Chamber of Commerce, along with its affiliated regional and local Chambers of Commerce, represents over 45,000 businesses in the State of New Jersey.

Chapter 83, Laws of 1978, is the law to promote the financial solvency of hospitals. It enables a system of cost shifting that has modified New Jersey's all-payer system to one of a limited and ever-shrinking base of payers. Those payers have become acutely aware of the impact of escalating health care costs and are looking for solutions.

Today you want to look at the uncompensated care system to determine how best it should be funded. The Chamber believes, and continues to assert, that the uncompensated care system can, and should, be further reformed to maximize savings and eliminate the need to open a new source of taxation. It is good to hear the Department of Health praise the cost-reducing efforts of reform. Permit me to remind you that those cost savings result from reforms implemented from the previous expansion, or extension of the Uncompensated Care Trust Fund several years ago, and that there are reforms that have recently been enacted in the July 1 Health Care Cost Containment Act that have yet to really be fully implemented and appreciated, so there are additional reductions in the

uncompensated care system that we can anticipate. Indeed, with proper controls the present surcharge mechanism, at a level somewhere below 12 percent, is preferable to other sources of funding currently under discussion.

The State Chamber categorically rejects and opposes the primary findings of the Governor's Commission on Health Care Costs submitted in October of 1990. The primary recommendation was to support Federal enactment of a universal health care system, a single-payer system. We believe that such a system would be brought to us with all the compassion of the IRS, employ the efficiency of the postal service, and have the budget of the Pentagon. Indeed, because there are those who still believe that government can provide health care more efficiently and in a more cost-effective manner than the private sector, there are still characters out there who can make a good living by selling bridges in Manhattan and swampland in Florida.

Another major recommendation of that Commission was to initiate a system of "play or pay" to require employers to either provide health insurance for their employees or pay a penalty. There are serious flaws in such a system, enacted, we would remind you, but not yet implemented in the "miracle" State of Massachusetts.

First, it would result in job losses by forcing employers to cut jobs and wages to offset mandated costs. It would drive toward a system of national health insurance, as more and more employers shift from private coverage to the public plan. It would create another costly government bureaucracy, and it would hurt small businesses, many of which do not provide insurance because of low or marginal profitability.

The State Chamber has often expressed its support for an uncompensated care system that guarantees that no citizen of our State shall be turned away from an acute care hospital

because of the inability to pay for services. We continue to support that policy. But the underlying purpose of the uncompensated care system was not to offer universal access, but, rather, to guarantee hospital reimbursement. Perhaps it is time to review and redefine uncompensated care and the related public policy.

While the Chamber would support continued guarantees to hospitals for providing appropriate care to the poor and needy, we believe that that reimbursement stream should be defined separately from reimbursement for bad debt.

At this point, permit me to assert that the Chamber believes that most of our State's hospitals are doing a good job. While it is prudent that all hospitals undergo complete periodic audits of their uncompensated care delivery and collection practices, those facilities which are demonstrated to be doing a good job should be permitted to continue to do that job, and should be encouraged to do so.

We have some specific suggestions that we believe will result in better management and cost savings to the system. Not all are directly related to uncompensated care, but all, we believe, will save money.

First, eliminate the "provision" method of allocating uncompensated care funds. The "bad debt" portion of uncompensated care is currently reimbursed on the basis of an accounting estimate of what that bad debt should be for a given hospital. It is called the, "Provision for Bad Debt." The hospitals are paid on that provision, instead of being paid on the actual bad debt. This should be changed so that hospitals are reimbursed upon the actual uncompensated care they deliver for both charity care and for bad debt.

We suggest that we eliminate uncompensated care bad debt coverage for uncovered procedures. Currently, as an accounting system to reimburse hospitals for costs they cannot shift, the uncompensated care system is blind to the cause of

bad debt. This may allow uncompensated care to be used for a variety of purposes which may not be intended. For example, the use of uncompensated care to reimburse hospitals for care which is not covered under an insured's health insurance policy should not be permitted.

Three, establish a centralized administration, collection, and audit system for uncompensated care. You have heard some comments on that already this afternoon. I would not further amplify that, except that we believe that such a system is workable. Senator Bassano and Assemblywoman Vandervalk have introduced legislation that would encourage a mechanism where the State could play a role in the collection of bad debt.

Four, base uncompensated care coverage on, and not to exceed, the State's new "bare bones" policy. Now, this may be a revolutionary concept, but it is difficult to induce businesses to cover their employees within a so-called bare bones, or basic health insurance policy, when uncompensated care is whatever care you want, wherever and whenever you want it. It's "sky is the limit" coverage. Uncompensated care coverage should be restricted to the policy limits of the recently enacted bare bones, or basic policy provisions, or some concept along those lines. Maybe not that precise, but some concept along those lines; that there be structures for what should be covered under uncompensated care.

Five, establish a retrospective review of all hospital emergency room visits with a "set-aside" for inappropriate use. One of the major abuses of uncompensated care is the inappropriate use of the hospital emergency room as a clinic by those without insurance. This must be eliminated -- not denying the care. Perhaps the easiest way to accomplish this would be to provide a reimbursement disincentive for each occurrence. When, upon retrospective review, it is determined that a particular uncompensated care patient was seen in the

hospital emergency room inappropriately, the hospital should be reimbursed at an outpatient clinic rate for that patient, instead of the higher emergency room rate.

This should be unlikely to put urban hospitals with large numbers of uncompensated care patients at risk, since their clinic structure makes them especially well equipped to triage these patients to appropriate clinic care.

It may be appropriate to improve reimbursement for outpatient clinic care where a hospital's percentage of uncompensated care seen in the emergency room decreases.

Sixth, we suggest we cover emergent care only for nonresidents of New Jersey. Currently, 95 percent of uncompensated care is provided to residents of New Jersey. Assuming that total uncompensated care equals about \$760 million, the 5 percent that comes from nonresidents amounts to a \$38 million burden on New Jersey citizens and businesses. This is hardly fair. Of course, emergency care should be provided to anyone requiring such care, but New Jersey should not become a care haven to those who are denied care in their home state. Hospitals should be reimbursed through uncompensated care only for emergency care rendered to nonresidents of New Jersey.

Carve certain treatments out of acute care and allow payment to physicians for providing that care. Care for certain illnesses is easily and more inexpensively provided outside of the acute care hospital setting, but because reimbursement for the uninsured rests within the acute care setting, the uninsured are precluded from obtaining that care elsewhere. It would make more sense to identify these illnesses and prohibit reimbursement for them within the acute care setting. In the alternative, physicians' offices, ambulatory surgery centers, and other outpatient settings could receive uncompensated care reimbursement for provisions for that specified care.

Eight, sunset mandated benefits. All mandated benefits should be subject to a "sunset" and then be reexamined in light of current economic realities in the delivery of health care. Only those benefits that demonstrably save costs and protect health through prevention should be considered for mandate.

Nine, allow part-time State employees to buy into the State health insurance benefits. It is hypocritical for the State to be asking businesses to expand coverage for part-time workers and dependents, when the State sets such a poor example. The State should immediately permit part-time State employees to purchase State health benefits at their own expense and at the State's preferential rate. Then the State could encourage businesses to follow this lead.

We would suggest that we audit State employee health benefits. The State Employee Health Benefits Plan costs the State many tax dollars, but is seldom adequately audited for abuse. All hospital bills provided under the State Employee Health Benefits Plan should be reviewed, by contract, with an independent auditing firm. Business is learning around the country that those audits of their third-party administrators are often able to save and find a lot of money, not through fraudulent activity, but just through clerical errors, the kind of thing that you could pick up in that kind of an audit. I believe one major airline found, over a three-year period, that it saved \$37 million, had it reimbursed. You don't do that every year, but you are not going to be paying that money out either. So, we would recommend such an audit.

Finally, coordinate State benefits with Medicare after fulfillment of co-payments and deductibles. The current "first dollar" coverage for retirees is an expensive and unnecessary entitlement for State workers. Other senior citizens are expected to assume responsibility for their deductibles and co-payments under Medicare. We should ask as much of our

retired State workers. The State would continue to provide full reimbursement beyond what Medicare will pay after deductibles and co-pays are satisfied.

The State Chamber is an active member of the HEAL -- Help Establish Affordable Health Care Laws -- Coalition, and we endorse the HEAL proposals. It is especially important that we enable the insurance industry to offer a marketable small group health insurance product that will attract additional employers to provide protection.

New Jersey, indeed our nation, has a health care system that is the envy of most of the world. While the system clearly needs reforms and adjustments, it would be a tragedy of catastrophic proportions to destroy it by turning it over completely to government management. A system that is more responsive to the free market and that empowers individuals to make their own informed health care decisions with government providing the safety nets, will best serve all of our citizens.

Thank you for considering the views of the New Jersey State Chamber of Commerce. We will be pleased to work with you and your staff to achieve solutions. Thank you.

ASSEMBLYMAN FELICE: Mr. Morford, thank you. This is an excellent report. I must commend you and your group. I know from a lot of the information here and from working with HEAL, that you have been a very active member, and have been very instrumental in this Committee in some of the legislation that has been proposed in the past. I just have to say, this is one of the best reports we have received to date among some of the others.

I would like to ask my members, does anyone have any questions for Mr. Morford?

ASSEMBLYWOMAN WRIGHT: I am not sure you can answer this here, but I would be interested to know-- On the bottom of page 2, which was your second recommendation, eliminate uncompensated care for uncovered procedures--

MR. MORFORD: Yes?

ASSEMBLYWOMAN WRIGHT: Do you have any sense of what the magnitude of that amount is? I think we would be interested in that.

MR. MORFORD: No, but I can find out. That is something that I could specifically gather some information for you on.

ASSEMBLYWOMAN WRIGHT: Thank you.

ASSEMBLYMAN FELICE: Thank you, Assemblywoman. Anyone else? Yes, Assemblyman Romano?

ASSEMBLYMAN ROMANO: I, too, would like to say -- as the Vice-Chairman said -- it is an excellent report. The topic for today was "Other methods of funding," etc., etc. and, you know, you shot right off with it. You know, you didn't mince words.

I just have a couple of comments, because each one of those we could spend time on. You know, the one about eliminating the provision of allocating funds, instead of on the bad debt they should be paid on the actual bad debt-- Now, you know, I know it is good politics. You can always get more than one bite out of the apple. But, isn't this also getting two bites out of the apple; that you are getting paid twice, if you will?

MR. MORFORD: I would suspect that some hospitals in the State may be getting less on their provision than their actual bad debt. It just seems to make sense to us that it should be-- The reimbursement should follow what is the actual bad debt.

ASSEMBLYMAN ROMANO: But did you follow what I am saying? There is a tendency here of getting paid twice, if you will, on a certain aspect of this.

MR. MORFORD: It is possible that some institutions could be being paid more through the provision because of some accounting practice than the actual turns out to be, yes.

ASSEMBLYMAN ROMANO: Okay, and I will go quickly with this: When we talk about -- because this has come up in many of the reviews we have made on health care -- the hospital emergency room visits with a set-aside-- I have been told that one of the problems that hospitals have with this idea of not paying for the rate of the emergency room is built into the malpractice situation, where someone comes into an emergency room and they are very hard put to make an immediate diagnosis, and to say, "No emergency care is needed. This can be another type of care."

Also, we talk about the emergent care for nonresidents of New Jersey. Mr. Morford, are you aware of what goes on today with the homeless, and what you are obligated to do for the homeless? Someone could walk in, not even give an address, give you the park, and you have to take care of them. Okay? So, you know, that is very hard.

MR. MORFORD: None of these are very-- I don't think that any of the suggestions are simplistic in their implementation. There are directions in which we should be going.

ASSEMBLYMAN ROMANO: No, no, I am just saying-- You know, I know you are coming from the right area, but as you go to scratch it a bit, the homeless-- You know, that is an area-- There is no address even. They can just say, "I got off the bus and I am going to sleep under a pole tonight."

MR. MORFORD: Certainly. I can understand that, and I can understand that a hospital has to be reimbursed for that if they have no way of determining an address. They have to assume at least that they are a New Jersey person.

ASSEMBLYMAN ROMANO: And then, lastly, we talk about part-time State employees. I think the State qualifies a full-time employee as 20 hours a week. Now, are you suggesting that someone who works less than 20 hours a week should have health benefits from the State?

MR. MORFORD: No. What I am suggesting is, those who are part-time employees of the State should be permitted--

ASSEMBLYMAN ROMANO: To buy in?

MR. MORFORD: --to purchase, at their expense, at the State's preferential rate, yes, which should be no cost to the State really.

ASSEMBLYMAN ROMANO: Okay. An excellent report. Thank you.

ASSEMBLYMAN FELICE: That's important, because I think a great percentage of those people who are on uncompensated care-- A lot of them are part-time workers. If they could be part of the program, they could be part of the solution.

Any other members? (no response)

MR. MORFORD: I think the State could then encourage the private sector to do a better job in that area, too, by example.

ASSEMBLYMAN FELICE: Absolutely. Thank you very much for your very fine report. We appreciate having you.

MR. MORFORD: Thank you, Assemblyman.

ASSEMBLYMAN FELICE: At this time I would like to ask Mr. Thomas Terrill, Executive Vice-President of the University Health System of New Jersey, to come forward. Did I pronounce that correctly, Mr. Terrill?

T H O M A S E. T E R R I L L, Ph.D.: That's fine. Thank you.

Chairman Colburn, Vice-Chairman Felice, and members of the Health and Human Services Committee, good afternoon -- or, it is close to good evening. I will try to make this interesting. (laughter)

You have heard some extremely good suggestions about what might be done to change our providing the financing and the operation of a very important Fund in New Jersey -- the Uncompensated Care Trust Fund. I would be more than willing to answer questions that are posed by my presentation today. I

could say that almost universally the suggestions you have heard so far from NJBIA, from the New Jersey Hospital Association, from the Chamber, are well-thought-out, very good, and most of which we would agree with.

The Univesity Health System of New Jersey is an organization which consists of the University of Medicine and Dentistry of New Jersey and eight of the State's major teaching hospitals.

I thank you for the opportunity to address the Committee today. Six of my institutions are in the top 25 beneficiaries of the Uncompensated Care Trust Fund. Before I begin, I would like to commend the Committee on its sponsorship of this hearing. Now, not June 30, is the time to begin considering methods of funding uncompensated care in New Jersey. This issue is of great importance to our citizens, and deserves a well-thought-out and carefully planned approach.

With nearly 700,000 of New Jersey's citizens currently without health insurance, the question is not whether there is a need for uncompensated care funding, but rather how this funding can be equitably financed and prudently provided. We believe there is enough money in the present Fund. If it is used wisely and well, health care costs can actually be reduced.

Under the present all-payer system, the burden of uncompensated care has been spread evenly across hospitals in the State through the use of a surcharge -- or a markup -- on all hospital bills. In addition to providing access to hospital care for New Jersey's uninsured population, this surcharge levels the playing field among hospitals. Let me explain:

Without any form of uncompensated care funding, true compensation among hospitals would not be possible. Those located in urban, and even some rural, areas of our State would be overburdened with a disproportionate share of the uncompensated care population, and, in order to pay for them,

would have to shift these costs to their commercially insured and Blue Cross patients, thus making them less competitive. On the other hand, some hospitals would not be faced with a large uncompensated care population, and would not have to shift costs to paying patients. Obviously, these hospitals would be in a competitively advantageous position.

Although the current system has succeeded in increasing access to hospital care for many of our State's uninsured and in distributing the uncompensated care burden in a more equitable manner across hospitals in the State, it has not been perfect. Basically, there are two major concerns related to the present funding method. The first is the fact that the current system increases hospital costs throughout New Jersey by placing a surcharge on each bill. This increase, in turn, raises the cost of health insurance. For those who have insurance coverage, the price of premiums continues to increase to cover the costs for those without coverage. However, for those without coverage, the accessibility of health insurance continues to move further out of reach, and, to the extent that they can pay their bill, the out-of-pocket cost also is much higher.

Some have questioned the legality of the current approach, which saddles the employers and welfare funds that provide coverage with the responsibility of paying for the care of others who do not. Questions regarding the implications to ERISA, in terms of interfering with employee benefits, also have surfaced.

The second concern related to the current uncompensated care system in New Jersey is the fact that it is inpatient biased. Because the payments are paid as part of the overall hospital reimbursement system, they only cover care that is provided on an inpatient basis or through hospital outpatient departments. As a result, the system does very little to improve access to basic, out-of-hospital primary

care. In other words, physicians do not get paid from the system for seeing patients in their offices, which is a tremendous force to reduce unnecessary use of expensive hospital emergency rooms.

Your first speaker today from Rutgers HIP spoke to that; the speaker just before me spoke to that. It is quite obvious that we need to expand the flexibility of how the fund can be used.

Well, what is the solution? Winston Churchill once said, "Americans always find the right solution, but only after exploring all other possibilities." We tried one. Let me suggest two other approaches: The first, which was proposed as part of the Governor's Commission on Health Care Costs, and advocated by some legislators as well, is a payroll tax that would replace the current surcharge. I am not afraid to use the word "Tax." I am an academic. I represent university teaching hospitals. The word is "Tax." It is spelled with a capital "T" -- ax. It has been estimated that a 1 percent tax on each employee's income up to a maximum of \$14,000 in wages, the current unemployment tax minimum, would yield approximately \$535 million. Funding of the current uncompensated care burden, which is estimated to be just under \$800 million, would therefore require either a tax of 1.6 percent, or an increase in the taxable maximum, probably up to \$25,000 to \$30,000, a much less regressive tax than taking it only to \$14,000.

Okay. One point the New Jersey Hospital Association made earlier was that if we don't change any funding levels now we are spending close to \$800,000. However, if we separate charity care from bad debt and build bad debt into the rates, the tax would not have to be as high as 1.6 percent. It probably could be 1 percent, and the \$535 million would be adequate to cover true charity care.

Implementation of this approach would eliminate the need for the added surcharge and reduce the cost of each

hospital bill by approximately 14 percent. This reduction, in turn, would translate into an approximate 6 percent or 7 percent decrease in health insurance premium payments.

The advantage of such an approach would be a reduction not only in health care costs, but also in insurance premiums. In addition, this method would remove some of the legal concerns currently raised about the relationship of the payment system to ERISA, and, in the minds of some, make the funding mechanism less of the "sick tax" that some consider the current surcharge to be.

Lastly, since the collection mechanism already exists through the unemployment tax, this would be easy and inexpensive to implement. What you have now is a hidden tax. What you have now is a suggestion to expand the present unemployment SUI tax for two purposes.

On the other hand, a payroll tax is just that -- a tax. Its impact on employers and employees, especially during recessionary times, needs to be considered. However, if insurers were to pass on the savings that would occur as a result of the elimination of the surcharge to those employers who provide health coverage, the added tax may be offset by the reduction in insurance premiums.

Others have suggested a second possible mechanism for funding uncompensated care through an insurers' tax. With the exception of Blue Cross, most insurers do not provide products in the individual insurance market or products that are guaranteed issue; in other words, coverage that would be available to everyone regardless of their health status.

It has been suggested that insurers who want to write health insurance in the State, but who are unwilling to provide such products, should contribute to providing access to the uninsured population. One way of doing so would be to require these insurers to contribute to the Uncompensated Care Trust Fund in lieu of offering such products. This "play or pay"

notion for insurers would serve to open up the insurance market for the uninsured, or would at least require companies to contribute to such an effort. Instead of paying a surcharge, insurers would contribute to uncompensated care funding in a more direct way. In addition, since there is already a premium tax, a mechanism exists to collect such funds.

However, this second approach is not without problems. First, because large employers tend to self-insure through ERISA, this tax would not be passed on to them and would primarily penalize small businesses which are much less likely to self-insure. This would spread the burden for uncompensated care over a narrow base that currently exists under the surcharge. As a result, such a tax would greatly increase the cost of insurance for those same employers and employees with coverage, and would possibly place them at a competitive disadvantage with other employers who do not offer coverage -- the concerns raised by Mr. Coe. This increased cost of insurance also would reduce the likelihood that employers and employees alike would continue to purchase such coverage.

And finally, it may be difficult to implement such a tax. If it were simply an add-on to the premium tax for all insurance, implementation would be easy. However, if the tax were being used as an incentive to get more insurers into the individual and small group market, then questions would arise as to how the tax could be equitably imposed.

What's the conclusion? The conclusion is you probably should think long and hard about an employer/employee based tax similar to the recommendations the New Jersey Hospital Association made earlier today.

The two approaches just described to funding hospital uncompensated care are approaches that could be considered and considered carefully. While the task of finding a solution to the problem may seem overwhelming, I think it is important to

remember that New Jersey, unlike most other states, has made a commitment to provide health care to all of its citizens. Because of the Uncompensated Care Trust Fund, our State is in a unique position. For New Jersey, the issue is not spending more, but using the funds more wisely and efficiently, and hopefully spending less in the end.

This is the challenge that we in New Jersey, as in the rest of the country, must face. The University Health System in New Jersey stands ready to assist you in this important endeavor, and thank you again for giving us the opportunity to present.

ASSEMBLYMAN FELICE: Thank you, Dr. Terrill. I commend you for your courage in coming out with the word "tax," a payroll tax especially, as one of the proposed alternatives to the surcharge.

Would any members of the panel like to ask a question? Yes, Assemblywoman?

ASSEMBLYWOMAN WRIGHT: I'm not clear on what the University Health System of New Jersey is. Could you just-- I know you mentioned something in your opening.

DR. TERRILL: Yes. It is a small consortium of eight teaching hospitals which are major affiliates of the University of Medicine and Dentistry of New Jersey. Our principal mission is really fourfold: to support and enhance graduate medical education and health professions education in the State; to serve as an educational vehicle for the regulatory authorities and the Legislature in areas of hospital administration, patient care delivery, and health services; the provision of cost containment efforts to group purchasing programs, credit and collection services which help to keep the costs down; and the fourth area is the clinical research capabilities which help our physicians partner with the pharmaceutical industry in the State of New Jersey to advance medical knowledge.

ASSEMBLYWOMAN WRIGHT: Are you speaking then on behalf, individually, of these eight institutions, or is this-- I am not sure of your relationship.

DR. TERRILL: Yes, I am. If you consider us a mini-hospital association, yes, I am speaking on behalf of those eight institutions.

ASSEMBLYWOMAN WRIGHT: And you are a nonprofit organization--

DR. TERRILL: Yes, we are.

ASSEMBLYWOMAN WRIGHT: --to which these groups fund the--

DR. TERRILL: They pay membership dues, yes.

ASSEMBLYWOMAN WRIGHT: Thank you very much.

DR. TERRILL: You bet.

ASSEMBLYMAN FELICE: Thank you very much. We appreciate your comments.

DR. TERRILL: Assemblyman, it was good to see you. Thank you.

ASSEMBLYMAN FELICE: The next speaker on the list here is Marc Lory, Vice President and Chief Executive Officer of University Hospital.

M A R C H. L O R Y: I am one of those eight hospitals, so maybe I can answer some of those questions.

Chairman Colburn, Vice-Chairman Felice, and members of the Health and Human Services Committee, thank you for the opportunity to speak with you today. My name is Marc Lory and I am Vice-President and Chief Executive Officer of University Hospital in Newark.

Coming from out-of-state as I did about six years ago, I was struck by the boldness and foresight that the New Jersey Legislature demonstrated when it sought to ensure access to the State's hospital system through the enactment of the Uncompensated Care Trust Fund. Your determination to abolish discrimination in health care has had, in my belief, as

significant an impact on the well-being of all of our citizens as any antidiscrimination legislation you have enacted.

I hope you will never second-guess the wisdom of your decision, because the concept of funding uncompensated care is as ethically and medically sound as it was at its origination. It is within the mechanics of collecting and distributing the funds that fault has rightfully been found, and it is within those mechanics -- not the basic tenet of equal access -- that radical changes need to be made.

There is no doubt that there is a tremendous need for a funding mechanism for uncompensated care. UMDNJ-University Hospital alone draws about \$62 million per year from the Fund, or about 27 percent of our annual budget. As you know, the total figure for the State is about \$754 million.

Where is this money being spent? There has been a great deal of speculation lately about freeloaders who simply choose not to pay their bills, or about hospitals that would rather draw from the Fund than aggressively pursue their debtors. It would be foolish of me to try to convince you that that never occurs. But it is vital that New Jersey's legislators and payers not ignore the evidence that under-insurance, which stems from high deductibles and co-payments, has created a vast new class of unwilling debtors among the low- and middle-income insured.

And, it is important that you don't ignore the large number of uninsured workers who are forced into an expensive, hospital-based system of care by the current uncompensated care regulations for the most basic, and presumably least costly, forms of health care. Because community-based clinics and private practitioners are not covered by the uncompensated care legislation, these individuals and their families are given one choice: an expensive hospital-based clinic, or no care at all.

Yes, there is a lot of room for improvement in our current system, both in the way that services are delivered and

the way that revenue is collected. The Department of Health and the New Jersey health care delivery system should be applauded for their vigorous efforts to reduce the drain on the Fund. We are informed that by year's end, New Jersey will have achieved something that has not happened in 10 years: a drop in uncompensated care payments -- and a hefty one at that -- an estimated \$85 million.

These savings were achieved in a very short time period thanks to a variety of initiatives, including: improved debt collection and payment documentation by hospitals; the SOIL program, which withheld tax refunds and Homestead Rebates; and expanding the availability of community-based primary care programs. Surely, the positive track record achieved so far with these and other initiatives deserves a more complete and lengthy assessment before the entire system is scrapped.

So, what should the Health Care Trust Fund look like on July 1, and who should pay for it?

I believe that a central fund from which hospitals would draw payment for strictly defined uncompensated care is the best mechanism we have to maintain accountability to the public and financial integrity for our hospital industry.

I believe an even more aggressive bill collection function should be required at each hospital, and that State-sponsored recovery programs like SOIL should continue to function. These components have been proven to be effective in reducing the level of debt, particularly among the numerous delinquent accounts that are under \$500.

I believe demonstration projects in which uncompensated care funds would be used to finance community-based primary care should be established in the areas of greatest need throughout the State. This effort will begin to make a dent in the millions of dollars being spent on \$150 hospital-based clinic visits for the same level of service that you and I pay \$50 for when we see our private physicians.

I believe that insurance reforms, including reducing mandated benefits and the introduction of new insurance products, should be made available and financially accessible to small businesses and the self-employed. We must give individuals and small business entrepreneurs a financial stake in the cost and design of New Jersey's health care system.

I believe that initiatives such as these, if given time and public and legislative support, can continue to reverse the escalation in uncompensated care payments. But they are not the complete answer. There will always be some level of true charity care and unrecoverable debt that must continue to be financed, if we are to maintain our commitment to nondiscrimination in health care. Who should pay for that?

Some of you may represent districts where relatively little demand for uncompensated care exists, and no doubt your constituents come to you and expect relief from the financial burden of paying for something they don't need. Why should Hospital A's bills be marked up to pay for uncompensated care at Hospital B?

Why, indeed? Why not make Hospital B mark up its own bills to pay for its own uncompensated care? Well, that essentially happened at University Hospital last year when the Trust Fund expired and our markup factors rose from a factor of two to a factor of three. Simply put, a \$10,000 hospital bill became a \$15,000 hospital bill overnight. And, while we have an extraordinarily high uncompensated care patient load, over 50 percent of our patients have Blue Cross, commercial, or Medicaid coverage. Over 50 percent of our patients' insurers were paying grossly inflated bills. How long do you think that would have gone on before insured patients were steered away from University Hospital, first on a voluntary basis, and ultimately through mandatory denial of claims?

And, when the insured patients leave University Hospital, and other hospitals like it throughout New Jersey's

cities and isolated rural areas, who will be left to pay for those who cannot? Where will society turn then for relief?

I don't think there is anyone in this room who would deny that the current system of taxing all hospital bills -- except Medicare -- to finance the Trust Fund is inherently unfair. Taxing the sick is truly adding insult to injury.

But the obvious solution to this dilemma is also the most unpalatable for those of you who must be reelected and for those of us who are already resentful of the tax bite New Jersey takes out of our paychecks. The solution is to spread the societal cost of uncompensated care out among the broadest societal base, through payroll taxes or income taxes. This approach may not be as bleak as it appears if insurance companies are forced to reflect their uncompensated care savings in their premium costs. These savings could then be used by businesses to support more benefits for their employees.

The true long-term answer to reducing the uncompensated care bill in New Jersey is to reduce the demand for health care services. Solve the problems of drug abuse, lack of prenatal and pediatric care, unhealthy life-styles of smoking and inactivity, violence, drunk driving, etc., and you will solve the problem of uncompensated care. Clearly, these problems will take years, if not decades, to resolve to any meaningful extent. In the interim, insurance reform, less costly delivery models for primary care, and the maintenance of a Department of Health-sponsored trust fund, are the most cost-efficient and ethically sound ways for the Legislature to reaffirm its commitment to equal access.

Last year, over 3000 people were admitted to University Hospital without any form of insurance. They were housed in the same type of room, were cared for by the same doctors and nurses, and had access to the same level of technology, as the other 13,000 insured patients taken care

of. That is no small achievement. In fact, it is quite an extraordinary achievement, and one that deserves our vigilant protection.

Mr. Chairman, I do not envy the enormous challenge that you and your colleagues are faced with as you deliberate the future of the Health Care Trust Fund. You are understandably frustrated by the many inequities and inconsistencies that are so clearly evident in our current system, and you want to take immediate, decisive action to right these wrongs. You have grown impatient with those who want to maintain the status quo and with those who pay only lip service to needed reforms.

But I implore you not to rush headlong into momentous change in the system simply for the sake of change. We are discussing what is probably the most complex health care issue facing our nation today, with far-reaching economic and sociological ramifications. No other state in this country has taken on this issue with as much courage, initiative, and determination as New Jersey has done. True, there are faults in the system, but where else in America can every man, woman, and child walk into the front door of every hospital in the State and receive needed health care services, regardless of their ability to pay?

The quick fix for the system is to return to the era of individual hospital surcharges, where the paying patients of any one hospital are completely responsible for the nonpaying patients of that institution. We concluded that system was just plain wrong in 1986 when the Trust Fund was created. Six years later it is just as wrong and poses as serious a threat as ever to the health and well-being of the uninsured and underinsured residents of this State and the hospitals that serve as their only source of medical treatment.

Instead, I call upon you to extend the Health Care Trust Fund until such time that an equally fair system can be

developed. This new system should incorporate community-based primary care, whether it is delivered through clinics, health centers, or by private practitioners. This new system should have built-in incentives for small businesses and individuals to purchase affordable health insurance coverage. And this new system should recognize that access to health care by those who cannot afford it is a societal responsibility that must be shouldered by the broadest base of our collective communities.

But most importantly of all, this new system should represent an even stronger commitment to the ethical and moral stand we took when the State of New Jersey put an end to the brutal discrimination of the almighty dollar in the health and well-being of its citizens.

Mr. Chairman, UMDNJ-University Hospital stands ready to assist you in any way we can. Thank you again for the opportunity to speak with you today.

ASSEMBLYMAN FELICE: Thank you, Mr. Lory, for an also very fine presentation. Members, any questions?

ASSEMBLYWOMAN WRIGHT: I would like to, but I don't think they would be relevant.

ASSEMBLYMAN FELICE: You have one?

ASSEMBLYWOMAN WRIGHT: I just wondered, since you are the first hospital that has testified which has had heavy experience with what happened when you didn't have uncompensated care during the first six months of 1991-- Can you talk about that, you know, as you experienced it? In just that short time, did it have any major impact on the delivery system?

MR. LORY: I think because of its short time frame, it would be really hard to impact it. I can talk about some of the impacts we felt. One was a reduction in cash flow as a result of not receiving the payments from the Fund in a prescribed way. We were not receiving cash in our institution, and it took us a while to get the cash back from the bills we

sent out, which then put us in trouble with our vendors because we could not pay those vendors in a timely fashion.

I could probably bring in a pile of complaints I received from patients after having received their bills relative to the markup factor problem, and some letters from some of the trust funds which questioned the ethicity of those bills at the time, and having to go through the hours of explanation to people as to why a broken bone on Monday cost "X" and a broken bone on Tuesday cost "Y," when, in fact, the same kind of care was being delivered.

I can only talk about the long-term effect of that -- which I have tried to articulate in this paper -- which is the fact that the insured base of the institution would eventually be whittled down, such that potentially what could happen is that the one insured patient who walks through the front door at University Hospital would receive about a \$62 million bill for health care, because that is exactly what happens when you shift that expense to your insured base.

ASSEMBLYWOMAN WRIGHT: My other question is: If you shift over to community health care-- Have you considered how that would be financed? Is that going to be something that would be part of health insurance? If I go to a Well Baby physical, for example, do you see any of that care coming through health insurance, or is this going to be private expenses, as it is today?

MR. LORY: Well, I can answer that question two ways, one for the third-party insurance holders, like a Blue Cross recipient. It depends on the plan they have. Some plans will cover prenatal care; most of them do these days. But the population that is utilizing the Trust Fund -- which is the issue here -- are not covered for that in a community-based program, because the Uncompensated Trust Fund does not cover either private physician office visits or health visits in an outpatient setting, other than one that is associated with the hospital.

We at University Hospital have several programs that are sponsored by grants from the State and Federal governments which allow us to provide that care and are not part of our clinic system. I think those are the kinds of issues. If one wants to go after reduction of the Fund, then one has to go toward reduction of utilization, and that goes into preventative health, and one has to provide access to that.

I heard some discussion earlier this evening about not allowing patients into our emergency rooms. I think it is a great idea, as long as there is an alternative. You know, it would be nice to be able to send the patient someplace. In a city like Newark, we do not have those accesses.

ASSEMBLYMAN FELICE: Thank you very much.

ASSEMBLYWOMAN WRIGHT: Thank you, Mr. Chairman.

ASSEMBLYMAN FELICE: Mr. Lory, thank you very much for your presentation.

We only have a few more left, not too many. I thank those who have been waiting for their patience, you know, but each one of them has an important message for this Committee.

At this time I would like to ask the next speaker, Melanie Willoughby, President of the New Jersey Retail Merchants Association, to come forward.

MELANIE WILLOUGHBY: Mr. Chairman, members of the Committee: I am Melanie Willoughby from the New Jersey Retail Merchants Association. I am also the Co-Chair of the HEAL Coalition. With me today is Maureen Lopes, Vice-President for Health Affairs for the New Jersey Business and Industry Association. She is the other Co-Chair of the HEAL Coalition. We are really very pleased to have the opportunity, early in the legislative session, certainly before the June deadline date looms ahead of us, to be able to lay our thoughts out on the Health Care Trust Fund and its component parts, and to be able to recommend to you our reform proposals to help fix this broken health care system.

I would like to explain a little bit about the HEAL Coalition, whose acronym stands for Help Establish Affordable Health Care Laws. We are a broad-based coalition of associations and businesses representing more than five million employees throughout New Jersey. The HEAL members include: the National Federation of Independent Businesses, the New Jersey Business and Industry Association, the New Jersey Food Council, the New Jersey Restaurant Association, the Retail Merchants Association, the State Chamber of Commerce, Health Insurance Association of America, the New Jersey Association of Builders and Contractors, the New Jersey Commerce and Industry Association, the New Jersey Association of Temporary Services, and, as you can see, many, many more businesses, both large and small.

We are here today to specifically address, certainly, the concerns about the Health Care Trust Fund. But, as you know, anytime you start to tinker with the whole health care system, start to tinker with the Health Care Trust Fund, it starts-- Like a little cookie, you squeeze it, and it will ooze out one side or the other. That is really basically the way we look at the Health Care Trust Fund. As we start to tinker with the component parts of that, we need to really address, comprehensively, reform of the whole system.

But today what we would like to do is address three areas that we feel are part of our prescription for health care reform. Those three are: Incentives to hospitals to collect bad debt; demographic study of recipients of uncompensated care to be able to determine the type of solutions needed to address each constituency that uses the Fund; and what we feel is most important, small business underwriting insurance reforms that will bring small businesses into the insurance marketplace, thus not utilizing the Fund.

According to the New Jersey Department of Health, approximately 82 percent of the uncompensated care for which

hospitals are reimbursed, is bad debt. A patient's bill may become bad debt because the patient cannot afford to pay, but does not qualify for charity care, does not know he or she may qualify for charity care, or might be a patient with adequate resources who may simply choose not to pay. It really could be that the patient did not pay his copay or deductible.

The high percentage of bad debt inherent in the Fund, and the large number of New Jersey residents who use the Fund, are really two major reasons we see for reform. One of the important steps toward assessing the utilization and functioning of the Fund was a study commissioned by the Legislature in 1991 to demographically describe the users of the Fund. The concern being explored is that the truly needy and truly uninsured are not the only beneficiaries of this Fund. You have heard a lot about that today. We anxiously await the official release of this information, because we feel it really holds the key to truly reforming uncompensated care.

We believe that there are many constituencies that use the Health Care Trust Fund. We believe that the collection data on these patient records from the hospitals will determine who uses the system, why they use it, and their ability to pay. Only after this determination is made can we really, truly start to build solutions for each one of these constituencies, for when you talk about someone who is not paying their copay or their deductible, what type of collection system do you need there? When someone is uninsured, how are we going to address that? How are we going to address, perhaps, a new definition for "charity care"?

HEAL's proposals go to the heart of the structural problems of the Trust Fund as a health care financing mechanism. Unfortunately, there are those who shy away from real reform in favor of ever-increasing reliance on additional funding. New Jersey does not have the fiscal luxury of throwing money at a broken, inefficient system of health care

financing. HEAL believes that the proposed payroll tax -- which you have heard so much about today -- to fund the Health Care Trust Fund, is not the answer. There is certainly no surprise there.

Small businesses, we feel, would really, truly suffer in these recessionary times with the imposition of a payroll tax at this time. I certainly agree with Assemblywoman Wright when she talked about how much do you really need, in terms of a payroll tax, to fund what is truly now the Uncompensated Care Trust Fund -- 1 percent, 2 percent, 3 percent, maybe 5 percent -- and how much of an imposition would that be on business right now during these times?

We feel reform is needed to reduce the bad debt and to reduce the cost of providing care to those without insurance. What I would like to do at this moment is-- We have charts that have been included in your packets, and at this point I would like to turn it over to Maureen, who is going to go over what we now know about the Health Care Trust Fund, and what some of our solutions are, as they address that. Then I will come back and talk about small group reform.

M A U R E E N L O P E S: Thank you. We have attached several, exhibits I will call them. The first one is entitled, "Who Pays Hospital Bills and Uncompensated Care?" The basic point of this chart is to show that in this State there are a number of different payers. As Mr. Coe said, Medicare pays for 42 percent of hospital bills, etc., down to self-pay at 6 percent. Because Medicare does not contribute other than to Medicare bad debt, you have to take that out of the calculation. So, uncompensated care, when you recalculate the percentages, shifts across that table. So now you have Medicaid picking up 18 percent of uncompensated care; Blue Cross, 25 percent; commercial, 42 percent; and even the self-pays, 10 percent of the \$750 million. I have done just an

estimate of what those dollars might look like in 1992. That is certainly part of the major concern here, that not all payers are participating.

The second page here is a description of charity care. It just summarizes. As many people have said, that is a regulatory definition. It is something that could be changed, and perhaps should be modified. I think HEAL New Jersey has consistently supported the need for public funding for those who truly need charity. It is certainly a sliding scale, which makes sense to us. That is not only a person's income, but the size of the bill that needs to be taken into account. I, personally, think that these are too restrictive. Some of the chart shows that if you are making \$22,000 a year for a family of four, you might be responsible for 20 percent of a hospital bill, with some caps, but that still could be significant dollars.

The third exhibit is, "Who Uses Uncompensated Care -- Bad Debt?" This information was taken from a December 1991 report of an initial survey that the Department of Health did. I just tried to make a simple chart of it. One of the key factors is, if you look at 60 percent of the bad debt, it is from people who are uninsured. So right there it says to you that it is not 100 percent. A lot of earlier speculation said if we somehow resolved the insurance problem, we would get rid of bad debt. That is not true.

Then, of those people who are uninsured, 53 percent of them are employed. So again, it is not the whole group of uninsureds who are employed. But we think our small group reform bill, and the concepts that Assemblymen Colburn and Felice have put forth, could really help this group of uncompensated care, and as Melanie said, she will discuss that further.

One of the other things I think is important to realize in looking at all these issues is that what started out

as a program to ensure the financial stability of hospitals, to make sure they are covered for bad debt and charity, at \$750 million is a major entitlement program in this State. I think we have to start looking at it that way, and with any entitlement program you look at who is eligible for it, and where is the most appropriate place to spend those dollars?

I think over time we have become convinced that if this were a program supported by general revenues that the Legislature had oversight for, more of those dollars would be going into community health centers and primary care up front, trying to decrease the use of acute care. But because the whole system has focused on acute care in hospitals, it is difficult to shift those dollars. So I ask, as we go forward, that you think of this more as an entitlement program, rather than strictly a hospital financing program.

And finally, we have provided a reprint of a chart that was published in the Asbury Park Press. They had reviewed information from the Division of Taxation coming out of that SOIL program in the past year. One of the key things here is a very high percentage -- 29 percent -- of people whose bills were bad debts, were making \$10,000 or less a year. That says to us, "Charity care needs a better definition." On the other hand, 28 percent of this group was making \$30,000 or more a year, which says to us that there is another group of people whom we would expect to have the ability to pay at least some of their hospital bill. That needs to be looked at separately also.

So, in terms of our recommendations, some of our suggestions-- Instead of focusing on trying to specifically spell out what steps every hospital should go through, we think that either the Legislature or the Department of Health should set standards; should review what would be an appropriate goal for every hospital to come in at. Just as in private industry you have these total quality management efforts now, where, on

a regular basis, you encourage organizations to look at their processes and continuously improve those systems, we think you could bring those ideas to bear on this by setting standards. Allow hospitals that know their communities best to then identify the procedures within that.

Other options might be -- and this may be fairly radical-- I mean, you certainly have the trade-off between being overly specific about procedures, or saying, "We are not going to reimburse 100 percent on the dollar," but then having some kind of a safety net for-- There could be several-- There may be inner-city hospitals which, for their geographical reason, have trouble with that less than 100 percent. But we have the mechanism within the Hospital Rate Setting Commission for that body to look at a hospital's total operations and all of their procedures to see if they need additional support in any one area of their revenue base. So you do have that safety net within your Chapter 83 already.

Thank you very much.

ASSEMBLYMAN FELICE: Thank you.

MS. WILLOUGHBY: Now I'm back for the remainder of our program. Now what I would like to do is talk about that section of the Uncompensated Care Trust Fund -- I still call it the Uncomp -- the Health Care Trust Fund, the group which is the working uninsured. This is the group we would like to specifically address in terms of our proposal, which has already been introduced by Assemblyman Colburn and Assemblyman Felice, Assembly Bill No. 757. This bill addresses small group insurance reform. We feel that not only putting a basic health care plan out in the marketplace -- what was accomplished last year by the Act that was passed by the Legislature -- but we feel we need to go one step further. We really need to completely change the underwriting standards for a small group business. That is what we would like to address, and being able to provide affordable and accessible health care coverage

for small businesses, so that we can bring that section of the working uninsured into the marketplace -- into the health insurance marketplace.

Realize that small businesses, those with less than 25 employees, are really in a catch-22 regarding health care costs. They are really very vulnerable to increased insurance costs. They employ the most New Jerseyans, and they are also the ones that have the least ability to spread the risk in terms of the costs. Most small businesses do want to provide health insurance for their employees, and nine out of 10 full-time employers currently have health insurance. However, increasing numbers of them, certainly during these times, have had a great deal of difficulty maintaining their health insurance, with no stability in the marketplace and with rapid increases in their premium costs.

What we want to do is have a piece of legislation that will become law that is going to address this; that is really going to provide rate stability, that is going to be guaranteed issue, and that is going to be able to put out a basic health care plan that is affordable. That is what we feel the bill that has already been introduced is going to do.

We feel that by, first of all, guaranteeing availability of coverage for small businesses, this would mean that employers with 25 or fewer employees would not be denied coverage, even if one or more of their employees or their dependents might otherwise be uninsurable or a high risk. Once insured, neither the group nor any individual in the group would be denied continued coverage because the group's or individual's health deteriorates.

Second, we would want to limit the rate spread. There should be a maximum permissible spread between each carrier's lowest and highest rate for each class of business. When you have rate stability, we feel that this will better improve small businesses' ability in the marketplace.

Rating factors for industry experience and health status which may be abused by some carriers, would also be severely limited under our HEAL proposal. These restrictions would eliminate the blacklisting of industries and pricing riskier groups out of the market.

We would want to limit the use of preexisting condition exclusions. Some carriers today impose an exclusion from coverage for medical costs associated with health conditions which arose before the health insurance policy was purchased. Under the HEAL proposal, a limit would be imposed on the length of time a carrier could exclude coverage for preexisting conditions, and insurance carriers could not impose new preexisting condition exclusions on individuals covered in the small group market when an individual changed jobs or employers changed carriers, two times when many small businesses can have difficulty with some of their employees who have a preexisting condition. This way changing jobs will not mean you will lose your health insurance.

Establishing a reinsurance program: By guaranteeing issuance of insurance to all small groups at premiums limited by the above-mentioned rating restrictions, the insurance industry is accepting more risk than it does currently. So, under the HEAL proposal, small group carriers would be permitted to reinsure eligible individuals and groups; in essence, buy another insurance policy on those likely to have claims which exceed the coverage provided by the premium.

In simple terms, reinsurance allows carriers to identify high risk cases and to purchase an insurance policy. They are protected by the marketplace at large from accumulating a disproportionate number of high risk cases.

This is not a new JUA because, first of all, it is privately funded; and second of all, no State costs are involved in this at all. Charges would be realistically set in relation to expected costs, instead of being set artificially

low. The reinsurance premium rates would ensure that only high risk individuals or groups would be reinsured and put into the reinsurance facility.

We also have as part of our proposal, certainly, the basic health care plan. We see this as being really critical, because it is a plan that is free of mandates. As we have talked about here this evening, mandates do hike up the costs of health insurance.

We would like to be able to provide to small employers the same benefits that large employers have right now who self-insure under ERISA. They do not have to provide the mandate that the State presently requires. Neither should small businesses have to buy them, unless they would like them, but then that would be a part of what they would request from the insurance company. It would be an option versus a requirement.

In conclusion, I would like to say that the HEAL Coalition is very prepared to work with you on these issues. We look forward to being able to reform the health care system so that there will not be a need for a payroll tax.

Thank you.

ASSEMBLYMAN FELICE: Thank you, Melanie.

First, Dr. Colburn has some questions for you, I think.

ASSEMBLYMAN COLBURN: I want to ask Ms. Lopes about the rates, or charges that would be allowed at less than 100 percent. You would have to go over the list of charges, say, in the ER, or some part of the hospital, and reimburse at less than 100 percent for some things. Is that what you had said?

MS. LOPES: You could do it by procedure. You could simply say, "All bad debt." I think it would make more sense, probably, to go over it by procedure. You would have to decide at what point in the process--

It was interesting, the earlier recommendation that you would wait until an outside collection agency had a go at

it before deciding whether it was bad debt or not. That is something I had not heard before, but it would be interesting to consider.

ASSEMBLYMAN COLBURN: Would you do that through the DRG system, with all the codes -- I guess you would have to -- this rate reduction, or reimbursement at less than 100 percent?

MS. LOPES: Or you could look at it-- The preliminary information also seems to say that a lot of the volume of the bills is in outpatient, rather than in the inpatient side of things.

ASSEMBLYMAN COLBURN: Yes, but the study we saw-- Wasn't that mostly inpatient? Am I wrong about that?

MS. LOPES: The big dollars are inpatient, but the number of bills are on the outpatient side. So, you might want to start with saying, "We are not going to reimburse 100 percent of the outpatient," which would be smaller numbers. That would be one way to try the whole experience -- the ER bills and outpatient clinic.

ASSEMBLYMAN COLBURN: Okay. Thank you. That is basically all that I wanted to ask.

ASSEMBLYMAN FELICE: Are there any other questions? (no response) Thank you both very much for a nice presentation.

I am going to give you a list of the people who are left to speak. The next speaker, of course, will be Timothy Harrington, from the Mid-Atlantic Health Group. Following Mr. Harrington we will have someone from the Bergen Pines Hospital; Gerald Tofani; and E. Von Lindern. I think that is our maximum list of the people here.

Timothy Harrington, now. Thank you for your patience.

T I M O T H Y H A R R I N G T O N: Mr. Chairman and members of the Health and Human Services Committee: It is a pleasure and an honor for me to speak before you today. My name is Timothy Harrington. I am representing the Mid-Atlantic Health

Group and its principal member, the Monmouth Medical Center, a 564-bed, acute care, tertiary teaching hospital in Long Branch, Monmouth County.

My testimony today includes a discussion of the principal factors behind the Fund's growth, the alternatives Mid-Atlantic Health Group has identified for its financing, and finally, a recommended course of action we believe reflects the political and economic realities of New Jersey and its health care system.

The sum total of all cost shifting in the acute care hospital industry is the accounting value of the Uncompensated Care Trust Fund. On a per-patient basis, the accounting charge is reflected as a 19 percent add-on to every hospital bill produced. The principal factors affecting the Fund's growth are a combination of socioeconomic forces, Federal Medicare policy, health care cost increases, and Fund regulations.

The most significant factor affecting the recent marked increase in the Fund was the elimination of the Medicare waiver. The Federal Medicare prospective payment system does not reimburse acute care hospitals for their reasonable costs. It is estimated that Medicare reimburses hospitals in New Jersey about 80 cents on every dollar spent on a Medicare patient. The 20 percent shortfall is cost shifted to all other payers. The main impact of this cost shifting on the Fund is seen in the Fund's bad debt component. Simply stated, the balances of unpaid bills are now larger.

It is clear that the Trust Fund is growing due to the increase in working men and women who no longer receive health care benefits through their employers.

New Jersey's economy today is fundamentally no different than that of other states. Individual health care needs tend to accelerate in recessionary times. Charity care costs rise as individuals increase the use of the acute care hospitals for primary care.

The Fund, itself, will grow as a function of the annual increase in the cost of providing health care in New Jersey hospitals.

Lastly, the regulations involved with the Fund contain no financial incentives encouraging hospitals to improve their collection activities. The negative compliance regulations only ensure that the hospitals follow a prescribed collection procedure. Having complied with the requirement, it then makes no difference if the hospital collects that dollar from the patient or from the Fund.

As long as universal access to care in New Jersey's acute care hospitals remains the order of the land, there will always be the need for its financing. Using this as a working assumption, the following alternatives are offered:

1) Continue the Fund as it is currently structured, and attempt to remove some of the contributing factors to its current size in real dollars and its rate of growth. Such initiatives would include:

* Mandatory basic health care coverage through all employers with a work force of 25 employees or more.

* Expansion of the eligibility parameters for the Medicaid Program.

Both of the above initiatives would have a permanent impact on the size of the Fund and its annual rate of growth.

2) Consideration could be given to establishing a public health care system for those unable or unwilling to pay for private hospital care. Several states, including Florida, utilize such a system right now.

3) The issue of universal access to, and more importantly, universal choice of health care is a decision based in public policy. Its current method of financing is through a user tax, which is inconsistent with public policy and law. The State, for example, finances the public educational system through a general revenue source. Should universal access to health care be treated differently?

4) The Health Care Trust Fund could be restructured and focused on two issues: charity care and a subsidization for New Jersey hospitals which experience an above average cost for bad debt. The restructuring would require developing an alternative source of financing. The result would be that the Fund, itself, would be much smaller, and its administration would be centered upon a smaller segment of the New Jersey hospitals.

The Mid-Atlantic Health Group applauds the efforts being put forth by you, Chairman Colburn, the members of your Committee, and the entire Legislature on this very complicated issue. We understand the political and economic realities facing all New Jerseyans, and recognize that some of the alternatives proposed are simply not presently feasible or require action beyond your control, such as the Federal government.

In a perfect world, we would want all the citizens of our State to have access to health care regardless of their ability to pay. We would also want the cost of health care to be free of the confusing mechanics of cost shifting. Finally, we would also wish to have the economic resources to finance the desires stated above, which in their aggregate total approximately \$800 million annually.

There are some steps that can be pursued. If taken in total they may not resolve the problem. They will, however, contribute towards whatever solution is ultimately found. We would urge you to consider the following:

- 1) Determine and understand exactly how much money is actually required to finance charity care in the State.
- 2) Determine and understand how much money would be needed to subsidize the hospitals which experience bad debt costs in excess of the statewide average.
- 3) Restructure that portion of the DRG reimbursement regulations that govern how hospitals are reimbursed for bad

debt. As stated previously, there is no financial incentive for hospitals to do anything beyond meeting the collection requirements established by the Fund. If the regulations were revised to create a permanent risk/reward process, hospitals would have the incentive to improve their billing and collection procedures.

4) Begin the dialogue aimed at the fundamental question of how we in New Jersey should address the public policy of universal access and universal choice.

5) Enlist the support of our Federal representatives in Washington in addressing the Medicare prospective payment system's shortfall in reasonable cost reimbursement.

In closing, permit me to thank you, Mr. Chairman and Committee members, for allowing me to comment upon the subject of these proceedings. If you have any questions concerning my testimony today, I will answer them to the best of my ability.

Thank you.

ASSEMBLYMAN FELICE: Thank you, Mr. Harrington. Do any members have any questions? (no response) We certainly thank you for your report, and for your patience in waiting to be heard.

MR. HARRINGTON: It was my pleasure. Thank you.

ASSEMBLYMAN FELICE: Next we will have the representative from the Bergen Pines Hospital. Is Mr. Ed Lewis here? (no response) If not, the Financial Director will speak. Will you please give us your name?

R O B E R T R A G O N A: My name is Robert Ragona. I am the Director of Finance at Bergen Pines County Hospital. I am going to be very brief, given the hour and the amount of testimony. I think they have covered just about every field. I am just going to address the issues that relate to my institution.

Bergen Pines is a division of county government. We are a 1200-bed facility. We are the largest provider of acute

psychiatric services in the State -- long-term care services. We have at least 30 clinics in place at our institution.

In addressing the issues here, there are all sorts of problems -- funding problems -- and I am glad I don't have to resolve them. There are insurance access problems. Again, they are other problems you are addressing. There are credibility problems on behalf of the hospital industry. I think Assemblywoman Vandervalk's bill would go a long way toward resolving those credibility problems.

I would just like to tell you what the impact on my institution would be if this Trust Fund were not renewed before the deadline. Basically, as a division of county government, we would be forced to contract. When that occurs, one or two things will happen: Either access is going to be denied to some individuals whom we are currently treating, or those individuals will be rechanneled into a more expensive modality of treatment. Those would be the simple consequences of not renewing the Trust Fund.

I know that does not make your task any easier, but I hope it will impress upon you the urgency of renewing the Trust Fund or coming to some other sort of a solution.

I don't think that experience would be unique to my institution. I think that all of the inner-city hospitals would suffer that same type of experience, one way or another. I think the people who would suffer the most would be those people who are least likely to come up to the podium to speak, because they are the people who have the least access, the least voice.

I thank you for your time.

ASSEMBLYMAN FELICE: Before we turn it over to the panel, just how much would you say the State Uncompensated Fund owes to Bergen Pines, at this time?

MR. RAGONA: Bergen Pines is owed enormous amounts of money from the reimbursement system. In 1992, we can

anticipate that the Chapter 83 share of that is around \$10 million. We do receive revenues from other sources for indigent care. We probably render \$30 million worth of indigent care at our institution, but the impact of this legislation is only in the \$10 million area for our institution.

ASSEMBLYMAN FELICE: Dr. Colburn has a question.

ASSEMBLYMAN COLBURN: This is something I meant to ask other hospital people: About how quickly do you get reimbursement from the Uncompensated Care Trust Fund once you let them know you need a given amount of money?

MR. RAGONA: The Trust Fund, itself, acts primarily as a cash flow mechanism which keeps an institution whole. It allows them to pay their vendors. Basically, it is a reconciliation process that is currently in place. We have some question as to whether it will be in place in the future. We receive payments out of the Trust Fund. All hospitals pay in, and then the hospitals that render the most care get paid out of the Trust Fund. It is a cash flow mechanism which allows hospitals to remain stable. We have the benefit of county government behind us, which helps, but there are limits. The County of Bergen traditionally subsidizes the health care delivery system to the tune of around \$10 million a year, and there are limits to that. We experienced that in 1991. There were layoffs; there were layoffs across the county. Part of that was the Trust Fund not being in place for six months.

ASSEMBLYMAN COLBURN: Some of the people have contended, or suggested, that hospitals are happier to get money from the Trust Fund than to pursue collections vigorously, because the Trust Fund pays more promptly now. I am still not clear. What do they do, give you a cash flow contribution on a regular basis based on your percentage of--

MR. RAGONA: It is a payment based upon an estimate, but it is a very, very limited payment.

ASSEMBLYMAN COLBURN: Okay. So, it is not individual bad debt or charity care that gets reimbursed specifically?

MR. RAGONA: Well, it is individual charity care that gets paid, and then the provision that they spoke to. I think if Assemblywoman Vandervalk's bill, as I understood it -- I had access to see it prior to coming here-- That would eliminate a lot of those problems simply because it would go to an actual basis. It would keep the hospitals whole. It would put the proper financial incentives in place to assure that a collection effort is made. I mean, if you don't make the effort, you lose the money. I can't believe that anyone in the industry would not make the effort.

As far as people preferring to collect from the Trust Fund as opposed to billing, I had an experience and I will just relate it to you: When I first came to the Pines, they were discussing closing sections of it. I remember that the then County Executive suggested that perhaps we should close our clinics down. They approached a lot of hospitals in the area as to, "Would you take up the slack?" No one stepped up to the line and said, "Well, we will collect more from the Trust Fund. Let's pick up the clinics that Bergen Pines is willing to close down." I don't think anyone is rushing in to pick up my market share.

ASSEMBLYMAN COLBURN: Okay.

ASSEMBLYMAN FELICE: Thank you very much. It was very informative to us.

We have two more speakers. The next one will be Mr. E. Von Lindern, Past President, Mental Health Advocacy Group of Bergen County, from Oakland. Thank you for your patience, waiting all this time.

E. V O N L I N D E R N: Let me be the first to say, "good evening," even though it has been evening for a while. I am the Past President of the Mental Health Advocacy Group of Bergen County. I came here, really, just to put an oar in for

mental health, if I saw that that was a problem. I see that that is one problem. Then, listening to the presentations this evening, I see that there are many other problems for us.

Mentally ill people, no doubt, are a large percentage of the people who cannot pay, who are unable to pay. For what reason? Because 20 percent of all people in New Jersey -- families -- will be touched by mental illness. I am a former patient. I have been hospitalized 11 times. I had a very nice sock but now it is pretty small, because that 19 percent and the DRG and everything else got a good piece of it. Plus, like everybody else involved in it, of course, I no longer had the very good job I had in the beginning.

That is one reason I would think you should look at the regulations you are proposing very carefully to make sure that the mentally ill have some -- what should I say? -- some consideration. You lose your job; your wife starts working again to support the family. The ability to recover your self-esteem is horrendous, and your money goes very rapidly today, as you know.

The second point I would like to make is-- Someone mentioned the "bad bones" insurance policy. We have written at least two dozen letters on this to the Commissioner of Insurance, because people with mental illnesses were excluded. I have been told that it will be included when it is finally approved, but I have not seen anything -- any letters from anybody to that effect. It has just been word of mouth that we will be included in the "bare bones" policy.

I can understand why the insurance companies don't want the mentally ill because there are many, many people who get mental illness. Certainly, I was fortunate. My illness occurred out of a clear blue sky. Even though I had difficulty holding onto things, I held onto my insurance policy through the date, and they paid 80 percent of all my hospitalizations.

Another thing we have in New Jersey is what I call the "double whammy." You not only get hit with the DRG situation, but then you get 19 percent on top of that, whether you are making \$10,000 a year or whether you are making \$50,000 a year. That is a flat tax on everybody. I'll give you two examples: A young man, 25, gets appendicitis. He goes in and he pays \$4000 for three days. His mother goes in six months later for another illness. She is in two days, and she pays \$5000. It is not the kind of math I learned in school. I had a hell of a lot of trouble with calculus, but I certainly could do basic arithmetic. I think you should look at that situation.

Somebody mentioned here, I think, who is really poor -- really poor? How do you determine that? This lady back here mentioned those making \$10,000 and those making \$30,000. Well, someone making \$30,000 may have a large number of children, or may have children in college, or may have many, many reasons why he should not pay, the same as the individual making \$10,000. So I would look at some way to say what a charity patient is.

As I understand it now from negotiating my son's bill -- it is \$1000-- One-thousand-and-one-dollars makes you middle class, and \$1000 makes you poor. One thousand dollars for our house would just pay about two months of the food bill. We keep no money in the house. We put everything in the bank. We draw \$100 as we need it. That is the way we operate our home. But certainly, \$1000-- To have more than that and be considered not poor-- In the case of the young man with appendicitis, he had several thousand more than that, because he works for an independent carpenter, a very small, three-men operation. His boss does not supply any benefits for those three men, and his car had to be replaced, not with a brand-new Ford Bronco, but with a secondhand truck. His pickup truck should have been replaced about two years ago. It is just going with baling wire.

In closing, I would like to say, I don't like to see the government getting into the insurance business. If the government wants to spend money on this problem, I would put it into the audit staff. Increase the audit staff. See who is making a strong effort to recover the bad debts and the problem payers, and I think you would get your money back many times for each auditor that you hire.

Thank you very much. Are there any questions? (no response)

ASSEMBLYMAN FELICE: Thank you, Mr. Von Lindern. I know the work you have done with the Mental Health Advocacy Group, and I commend you for your continued input to, not only myself, but to other legislators and to this State. We hope you will continue to give us that kind of information.

MR. VON LINDERN: Thank you.

ASSEMBLYMAN FELICE: We have one more speaker here, Mr. Tofani, who is Vice-President of Finance, St. Peter's Medical Center, in New Brunswick. Thank you for waiting.

GERALD TOFANI: That's quite all right.

Good evening, and thank you for this opportunity to address the Committee. I apologize that I do not have a written copy of my testimony, but I will try to be very brief. Being last, I hope you are not expecting me to have all the answers. (laughter) I'm sorry I don't, but I would very much like to be part of the solutions.

I believe that New Jersey's hospitals cannot survive without reimbursement for uncompensated care. Many people today have addressed the need for uncompensated care. In the issue of being brief, I would like to focus my comments on what should be included in uncompensated care.

Currently it includes charity care and bad debt. I have heard sentiment today that charity care should be reimbursed, but that bad debt should not. Surely the term "bad debt" sounds like you have done something wrong, but: every

business that cannot demand total payment in cash up front will incur some level of bad debt. The key question is, "How much is an acceptable level of bad debt?"

Loosely defined, charity care applies to people who cannot afford to pay. Similarly, bad debt applies to people who do not pay. However, these simple definitions are no longer valid. Hospitals should not be penalized for their inability to collect an account, which any other good business also would not be able to collect. So the question is, "What is a reasonable standard to compare hospital collection rates to?" Surely a hospital's collection rate could never be as good as a bank's. Banks are very selective in whom they lend money to. Hospitals do not have this luxury. Banks go through a long, thorough credit analysis of each applicant. They refuse to lend money to many people whom they consider poor credit risks. In other words, banks do not lend money to people they think may not repay the loan. However, hospitals must treat, and extend credit to, the same credit risks. They must treat every patient. Actually, we would like to treat every patient who comes to our door. Hospitals should not be penalized for their inability to collect money from someone a bank will not lend money to.

For similar reasons, hospital collection rates will never be as good as those of major credit card companies. Credit card companies also screen their applicants, and will not give a card to people they perceive as poor credit risks. But hospitals have to treat all those people who cannot qualify for credit cards. Chapter 83 protects who American Express rejects.

When credit cardholders default on their payments, their privileges are suspended; their cards are taken away. However, hospital patients who have a history of not paying cannot be denied service, and they come back to our clinics

week after week. Hospitals should not be penalized for their inability to collect money from a patient who cannot quality for a major credit card.

Currently the definition of "charity care" is tied to national and State poverty guidelines. Poverty guidelines relate to a person's income level and family size. But poverty guidelines are not a do all and end all indication of who is likely to pay his bills. A major bank or credit card company's lending policies are a better indicator of who you can expect to collect from.

But, despite all their financial screening and their excellent collection efforts, banks and credit card companies incur a certain level of bad debt, and they pass this cost of doing business along to their paying customers by increasing their prices.

I heard on the way over today on the news that New Jersey has the highest rate of mortgage defaults in the continental United States, second only to Alaska. You know, anyone who has ever applied for a mortgage knows the lengthy process you go through; again, things that a hospital does not have the luxury to do. Despite that lengthy process, they are still having problems. Hospitals should not be penalized for their inability to collect an account that a bank or a major credit card company cannot collect.

In summary, I believe that hospitals should be reimbursed for patients whose income is below poverty guidelines, and patients who cannot quality for an unsecured loan from a major New Jersey bank or major credit card company.

In addition, hospitals should be allowed a reasonable amount of bad debt expense which is equal to the bad debt experience of these major lending institutions. However, hospitals should have the responsibility to collect those same accounts that would be collectible by a bank or a major credit card company. If a bank can collect it, we should be able to, too.

These concepts are easier to discuss than to implement. However, if we can agree on some of these concepts, I hope that in the future we can work on a practical implementation of them together.

ASSEMBLYMAN FELICE: Thank you very much, Mr. Tofani. Does anyone have any questions?

ASSEMBLYMAN COLBURN: None. Thank you.

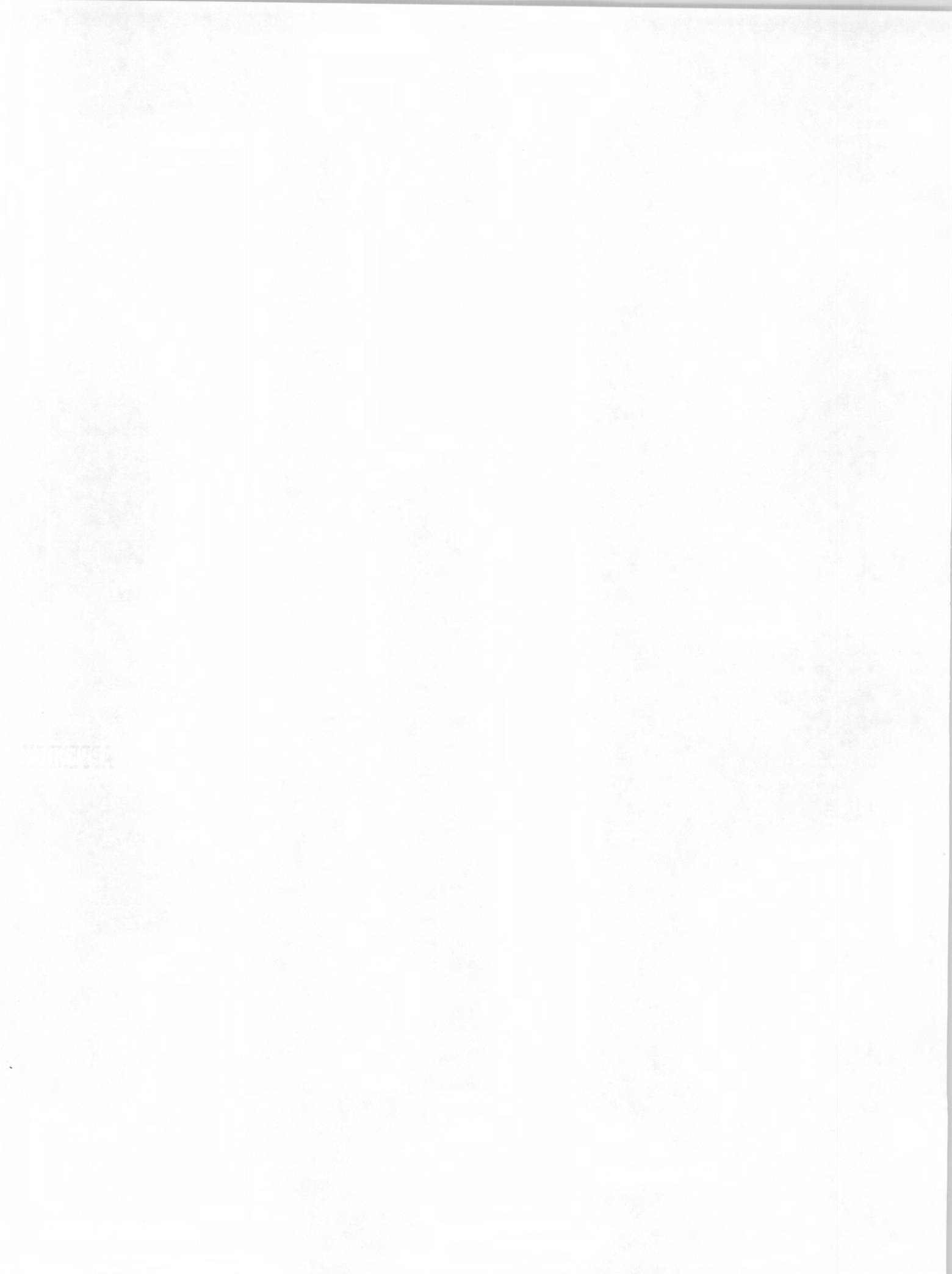
ASSEMBLYMAN FELICE: Thank you very much.

That concludes our last speaker. I would like to thank all of the people who participated and gave us their input tonight. I would like to thank, of course, Chairman Colburn and the members of the Committee, who have been very attentive to the input we have been getting. And naturally I would like to thank the audio/visual staff -- Mike Azzara and his staff -- who helped to arrange this, and the hospitality and cooperation of Valley Hospital, and of course our recording group here.

We thank you all for really helping us on the Health Committee to get a handle on what is happening with uncompensated care. Thank you very much, and get home safely.

(HEARING CONCLUDED)

APPENDIX



The New York Times

NEW YORK, WEDNESDAY, MARCH 4, 1992

New Insurance Practice: Dividing Sick From Well

By GINA KOLATA

In a new practice, some health insurance companies are starting to divide the sick from the well, even in large groups that were once a bastion of security in a tumultuous industry.

Families in large groups had always felt that if they had been part of the group for at least six months or a year, their medical costs would be covered and their premiums would remain stable. But now, some insurance companies are dramatically raising rates for sick people, and even for people they think may become sick.

The result, said Dr. Norman Daniels, an ethicist at Tufts University who is an expert on health insurance, is that "no one in this country with private health insurance coverage who is in any kind of group plan is free from the kind of uncertainty that competition is producing."

He added, "We are beginning to see that people who have the greatest access to health care in this country are at risk."

\$16,000 Annual Premium

No one knows how common it is for insurance companies to raise the rates for the sick in large groups, which usually consist of employees at big corporations or members of special-interest organizations. But the experience of Kathleen Renshaw of Leucadia, Calif., and others shows that the problem, once thought to be lim-

ited to small groups, is spreading to large groups as well.

Ms. Renshaw finally admitted defeat in her struggle to keep group health insurance for her family when the annual premium reached \$16,000 a year. Her problem is her 8-year-old daughter, Marisa, an exuberant child who swims on a team and takes singing lessons.

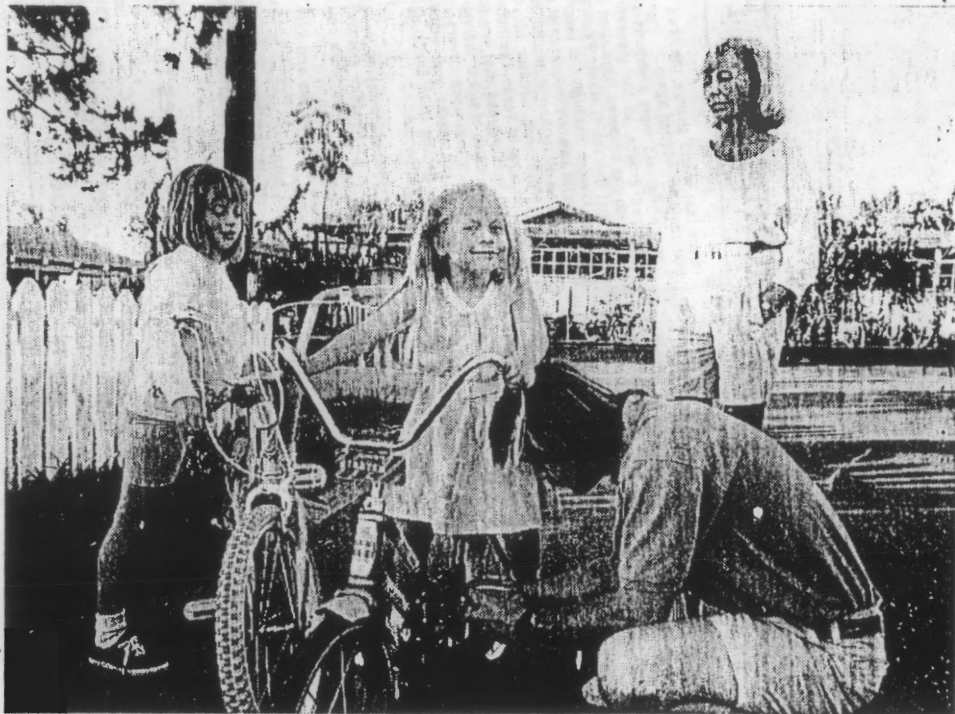
But Marisa has only one kidney, and it does not fully function. She needs regular checkups and may face kidney failure in the future. When the family's insurance company learned of the problem, which doctors discovered when Marisa was 3, it began doubling the family's health insurance premiums each year, the maximum increase allowed by California law.

Who Is at Risk?

Finally, the family could no longer pay. And no other company would insure them. Along with Marisa, Ms. Renshaw, her husband, William Harvey, and their 4-year-old daughter, Kirsten, who has no medical problems, were out in the cold even though they had been part of a large group with health insurance.

Ms. Renshaw and Mr. Harvey never thought they would be without health insurance. They both have jobs, they bought group health insurance through the

Continued on Page A15, Column 1



Marisa Harvey's kidney problems prompted her family's health insurance company to double their premiums annually until the family could no longer

pay. With Marisa, left, outside their home in Leucadia, Calif., are her mother, Kathleen Renshaw, her father, William Harvey, and her sister, Kirsten.

Robert Burroughs for The New York Times

Insurers Dividing Sick From the Well

Continued From Page A1

alumni association at the University of California at San Diego, and they always paid their premiums.

"I thought that when you pay insurance, the insurance companies will pay for you when you get sick," Ms. Renshaw said. It was a shock to learn otherwise, she said.

Dr. Donald Light, a sociologist who is professor of health policy at the University of Medicine and Denistry of New Jersey, said the family's experience was "a tragic example of the spiral of exclusion that is spreading through the entire health care industry."

The Renshaw family fell victim to a practice that Dr. Light calls policy churning. Each year, the company would raise its rates. At the same time, it invited its members to reapply for an attractive low rate for new subscribers. But people who were sick or had a pre-existing condition were turned down for the lower rate when they reapplied, forcing them to accept whatever rate the company would impose.

Dr. Light said group insurance programs until recently covered any member who became ill. The costs for the sick people were spread over the entire group. But the new trend changes the rules so that group members who become sick or, the company suspects, may become sick, have to pay much more for their coverage.

Dr. Light said the practice began in small groups, like self-insured small businesses, in the mid- to late 1980's. While it is still most common in small groups, he said, it is spreading to larger and larger groups. The group that Ms. Renshaw and Mr. Harvey joined had thousands of families.

Dr. Daniels said practices that weed out the sick are the insurance industry's way of remaining competitive by selling insurance at low rates to people who are well. "What's really at work are a set of economic factors," he said. Insurers realize that people who are healthy will shop around for the lowest rates they can get, so insurers have to compete with each other to attract this healthy, income-generating group. The sicker people, however, cannot shop around because no other company will take them or will charge them rates at least as high as they are currently paying. So, Dr. Daniels said, "insurers have underwriting procedures to sort people out."

The administrator of the alumni group insurance, Association Consultants Inc. of Chicago, said that the group had offered attractive low rates to new subscribers, forcing members of the group to reapply regularly or pay much more. But, said William Richard Floyd, the vice president of Association Consultants, the group had no recourse. "The greatest fear any plan has is that new applicants will stop coming in," he said. "If you stop that flow, the plan will terminate because of poor experience."

Dr. Uwe Reinhardt, an economist at Princeton University, said the insurance problems that beset Ms. Renshaw's family were a graphic example of why he calls the American system health "unsurance" rather than health insurance. He added that these problems show why health care had become a potent issue in the current election campaign.

Donald B. White, a spokesman for the Health Insurance Association of America, which represents commercial insurance companies, said that what happened to Ms. Renshaw's family was unacceptable. And he said it was because of cases like hers that "we and everyone else, are proposing re-

forms that would change the laws so that could not happen again."

Mr. White said most problems are with small groups, so the insurance association has proposed legislation to change that market. It wants Federal laws to guarantee that high-risk people in small groups can buy insurance at a cost that is no more than 50 percent of the average premium. Senator Lloyd Bentsen, Democrat of Texas, has introduced a bill in Congress that would prevent the exclusion of sicker individuals from health insurance coverage sold to small businesses and would prevent small groups from canceling policies of sicker people.

But these remedies do not address the situation that Ms. Renshaw and Mr. Harvey faced because they were not insured with a small group.

Ms. Renshaw said that she and her husband purchased their insurance after Marisa was born. Mr. Harvey, who is self-employed in the construction industry, had no employer to offer in-

When it comes to coverage, there's no longer safety in numbers.

urance and neither did Ms. Renshaw, who until recently worked as a photographer and is now a substitute teacher.

Marisa, however, was not a healthy baby. She failed to gain weight as she should have and no one knew why. Finally, when Marissa was 3, her doctor discovered that she had just one kidney and it had been permanently damaged by a urinary tract infection.

A year later, the family's insurance premiums started to escalate. In two increases over the course of the year, the rate soared from \$1,552 a year to \$3,080 a year. The company did say, however, that Ms. Renshaw and Mr. Bradley could reapply for insurance and, if accepted, get a lower rate. They applied and were rejected, meaning they were stuck with the soaring rates. "That was how they separated the sick people from the well people," Ms. Renshaw said.

To reduce their premiums, Mr. Harvey dropped out of the program and went uninsured. That brought the premium to \$3,160 a year.

But the next year, in February 1989, the rate was increased again to \$4,420 a year. In February 1990, it rose to \$8,844 a year, payable quarterly. "We made two of those payments, but it was getting to the point where our health insurance was as much as our mortgage," Ms. Renshaw said. Then, she said, she got a telephone call from the company saying it was raising the rate to \$16,000 a year.

In desperation, Ms. Renshaw tried calling her alumni association but, she said, they offered no help and, eventually they stopped returning my calls. She said she also called members of the California Assembly. "They said 'That's too bad. You should start a grass roots petition,'" she recalled.

Ms. Renshaw and Mr. Harvey tried to find another company to insure the family, but none would. The best they could do was get minimal coverage for their daughters. They said they were told by the companies that they could get coverage for the family if Marisa's kidney was excluded, but the cost of paying for all of Marisa's sonograms and checkups for her kidney as well as the health insurance premiums would reach at least \$7,000 a year. They could not afford it, Ms. Renshaw said.

Limited Coverage Now

Through a catastrophic health insurance plan of the California Children Services, Marisa is now covered for major problems with her kidney, but nothing else. And this coverage, Ms. Renshaw said, is available only if a family of four has an income of \$40,000 or less. But if Ms. Renshaw gets a full-time teaching job, which she has been seeking, the family would be disqualified by its income. In that case, she said, "our next option is a divorce."

Kirsten is covered by an individual Blue Cross policy with a \$1,500 deductible. But the policy excludes payments for her sinus, because she has had two sinus infections. And it will not cover any problems with her eyes because Ms. Renshaw once took her to an ophthalmologist, mistakenly thinking that her eyes were crossed.

Ms. Renshaw said her search for insurance has led her to get a teaching certificate, rather than one in marriage and family counseling, which she preferred, because she does not want to be self-employed. As a teacher, she reasoned, she would have a chance of getting insurance through the school system. And she has is putting off having a baseline mammogram until after she gets insurance for the family, afraid that if the mammogram detects any suspicious lumps in her breast, she would fail to get insurance.

As she applies for a teaching position, Ms. Renshaw said that she is afraid to mention Marisa's kidney problem. "I might not get a job," she said.

And she and her husband live in terror of illness because medical bills could easily bankrupt them. "I'm afraid we'll lose our house," Ms. Renshaw said. "That's the only thing we have."

2X

**EXPANDING HEALTH INSURANCE COVERAGE:
Lessons from the Robert Wood Johnson Foundation
Health Care for the Uninsured Program**

**1991 Health Policy Forum
Health Care Reform - Insuring the Uninsured**

September 24, 1991

**W. David Helms, Ph.D.
President, Alpha Center
and**

**National Program Director
Robert Wood Johnson Foundation
Health Care for the Uninsured Program**

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4
3X

FROM HEALTH INSURANCE PLANS
TYPES OF INDUSTRIES OFTEN EXCLUDED

TYPES OF INDUSTRIES OFTEN EXCLUDED FROM HEALTH INSURANCE PLANS

Amusement Parks
Asbestos-Related Industries
Auto Dealers
Aviation
Barbers and Beauty Shops
Bars and Taverns
Car Washes
Commercial Fishing
Construction
Convenience Stores
Domestic Help
Entertainment/Athletic Groups
Exterminators
Federally Funded Organizations
Florists
Foundries
Grocery Stores
Health Clubs and Spas
Hospitals and Nursing Homes
Hotels and Motels
Insurance Agencies
Interior Decorators
Janitorial Services
Junk and Scrap Metal
Law Firms
Limousine Services
Liquor Stores
Logging and Lumber Mills
Meat/Fish Packers
Mining Operations
Moving Companies
Oil Field Operations
Parking Lots
Physicians' Practices
Restaurants
Roofing Companies
Security Guard Firms
State Funded Organizations
Taxicabs
Trucking Firms (Long Haul)

4X

Testimony Provided to the

Assembly Health and Human Services

Committee

**Regarding the NJ Health Care Trust Fund
and Alternative Means of Funding Hospital
Uncompensated Care**

Provided by:

Charles A. Mowll

Vice President, Finance

New Jersey Hospital Association

March 5, 1992

5X

Testimony Provided to the Assembly Health and Human Services Committee
Concerning the
New Jersey Health Care Trust Fund
and Alternative Means of Funding
Hospital Uncompensated Care

Introduction

I am Chuck Mowll, Vice President of Finance for the New Jersey Hospital Association and, on behalf of our member hospitals, I appreciate the opportunity to provide the Committee with a review of the Association's position regarding the funding of hospital uncompensated care. The Hospital Association's position regarding the uncompensated care trust fund has been consistently and clearly articulated over the many years of public debate as the state legislature has been challenged and re-challenged to formulate a legislative solution to protect this extremely important funding mechanism - A mechanism which ensures access to hospital care for the least fortunate of our state's residents, the medically indigent. The Hospital Association wholeheartedly endorses the continuation of an uncompensated care trust fund to address the very issues identified in the preamble of the current Health Care Cost Reduction Act which details, among other things, the provisions of the current Health Care Trust Fund:

"Access the quality health care shall not be denied to residents of the state because of their inability to pay for the care . . ."

The purpose for the uncompensated care trust fund, which is clearly defined in the Act, is to:

- Ensure equal access to hospital care
- Maintain a mechanism that will ensure payment of uncompensated hospital care
- Protect the fiscal solvency of hospitals

However, the Hospital Association also wholeheartedly believes that the current definitions of uncompensated care, the current financing mechanism of uncompensated care, and the scope of the current uncompensated care trust fund must be dramatically changed for appropriate incentives to be in place and for desired health care system goals and objectives to be achieved.

NJHA envisions these desired goals and objectives as:

1. Reducing the size of the uncompensated care trust fund by clearly differentiating between bad debt and charity care.
2. Eliminating the current hospital "bed tax" for the provision of charity care by broadening the funding base for this societal responsibility through an employer/employee assessment similar to the state unemployment insurance deduction, rather than a hospital bill surcharge paid by either employers or patients, directly or through increased insurance premiums.
3. Defining the employer/employee contribution for the care to the indigent that provides appropriate

incentives to employers that encourage the provision of health care coverage.

4. Administering a newly created trust fund as a managed care, enrollment required, insurance company type fund requiring individual charity care claim submissions, a centralized patient database with required screens for Medicaid eligibility, existing insurance coverage, and potential Homestead Rebate or income tax refunds.

Beyond these objectives, the Hospital Association will urge the Committee to consider the following specific recommendations.

The Hospital Association will be providing additional clarification to these recommendations as our Board of Trustees finalizes the Association's position for uncompensated care legislative change which will be shared with this Committee in the very near future.

Uncompensated Care Definitions

Before discussion of uncompensated care funding is pursued, a clear assessment and definition of the elements of uncompensated care must be determined. Currently, the state's \$754 million of uncompensated care is inappropriately defined as comprising 82% of patient bad debts and only 18% of charity care services. The Hospital Association believes that if properly defined, charity care would more realistically represent approximately 75% of the provision of uncompensated care services in the state or \$560

million of the \$750 million currently being provided. The causes of this problem can be simplified into two basic areas:

1. The Department of Health's rigid enforcement of extremely detailed charity care regulations in reality creates a situation where the majority of charity care services are identified as bad debt services simply because the hospital is unable to meet the stringent patient documentation requirements. For example, thousands of patients access our hospital emergency rooms for emergency care and are unprepared or unable to provide the income/expenses, assets/liabilities information or the required detailed documentation of this information to the hospital. These patients are also unable to provide the necessary medical assistance screening requirements that would help qualify these patients as charity care patients. Most of these patients have very limited resources or income but as a result of their inability to provide documentation are classified as bad debt patients.

2. The regulatory definition of the income threshold for a patient to qualify for full charity care is absurdly low. For example, a family of four with gross income over \$20,100 would exceed the charity care/poverty income guidelines established by the state's regulations. Mind you, this is defined as gross income, therefore, a deduction of the normal 30% federal, state and social security, taxes and

assessments leaves a patient with a family of four with net income over \$14,070 disqualified for full charity care. It is not hard to believe that many of these patients end up not paying their hospital bills when accounting for true disposal and discretionary income (that income after paying one's housing, food, and clothing expenses). The charity care threshold is currently defined at 150% of the federal poverty income guidelines published each year. This threshold must be substantially increased to properly identify those patients who are truly unable to pay their hospital bills. Additionally, there must be a catastrophic health care provision defined under future charity care legislation/regulation. This catastrophic charity care provision must provide that no individual in New Jersey should be required to pay more than 20% of the higher of their annual income or net worth in any one year for medically necessary hospital care.

Currently, the inappropriate definition of the bad debt component of uncompensated care has caused a dramatic overstatement of the actual level of bad debt and a dramatic understatement of the actual charity care level. Most of the bad debt patients are truly indigent patients and should qualify for charity care services. The current stringent regulations mandate an automatic default of charity care patients to the bad debt classification if the patient is unable to provide the necessary documentation. This misclassification of

uncompensated care patients is of extreme concern to the New Jersey Hospital Association and New Jersey's hospitals since the public perception (including patients, payers, state legislators, and the state's administration) is that the majority of hospital uncompensated care is bad debt, that hospitals are simply not doing a good enough job to collect this bad debt, and therefore, hospitals should not be fully reimbursed for their uncompensated care costs.

The importance of appropriately defined uncompensated care, bad debt, and charity care elements of hospital care to the examination of the uncompensated care trust fund issue cannot be over emphasized. The appropriate definition of charity care services has far-reaching implications well beyond the establishment and administration of an uncompensated care trust fund in New Jersey. The provision of charity care services to New Jerseyans is the basis for the tax exempt status and mission of New Jersey's acute care hospitals. The appropriate definition of charity care services is important to maintaining hospital tax exempt status and to compliance with generally accepted accounting principles as defined by the accounting standards industry. The American Institute of Certified Public Accountants (AICPA) defines bad debt expense as "the provision for actual or expected uncollectibles resulting from the extension of credit" and charity care as those services provided "free of charge to individuals who met certain financial criteria." The Principles and Practices Board of the Healthcare Financial Management Association (Chicago, Illinois), which establishes accounting

definitions and principles for health care institutions, defines bad debts as "the result from services rendered to patients unwilling to pay" and defines charity services as "services provided to individuals who are unable to pay."

Since bad debts are a cost of doing business or extending credit to hospital patients, this element of a hospital's cost (substantially reduced as a result of the redefinition of charity care) should be directly included in the hospital's rates as an approved element of cost under the state's rate setting system.

The remaining charity care portion of the state's hospitals' uncompensated care provision should not be included as an element of a hospital's rates set under the state's rate setting system, should not be included as an element of a hospital's billing mechanism, but should be funded more broadly through an employer/employee assessment (the provisions for which are discussed below).

Funding

The trust fund should be redefined as a fund to provide payment to New Jersey's hospitals for the provision of care to the indigent through a broad-based employer/employee assessment. The fund would be established as an insurance type fund with hospitals receiving an initial prospectively determined payment and employers/employees paying a prospectively determined assessment. Hospitals would be required to submit directly to the trust fund administrator individual patient bills for charity

care services provided. In this way, the fund administrator would be able to reconcile the prospectively determined hospital payments and employer assessments with the actual provision of charity care services among New Jersey's hospitals.

In the future, a managed care provision could be built into the administration of the fund with the administrator developing preferred provider organizations for the provision of managed health care services through physician or patient assignment. Other important elements of the fund could include:

- Patient enrollment in the Fund requiring a one-time application which could be updated upon future patient visits
- Maintenance of a centralized database of patient access to New Jersey's health care system
- Patients issued identification cards and patient numbers
- Clearance of all charity care patients through a centralized insurance coverage database to identify existing insurance coverage
- Screening for medical assistance eligibility (with assistance of the Division of Medical Assistance)

- Coordination with the Department of Treasury for potential offset of homestead rebate/state income tax refunds

Employer/Employee Assessment - Funding Source

Funding for the provision of hospital charity care services to the indigent should be financed through a payroll assessment, the expense of which should be shared by employers and employees.

The Hospital Association recommends that for those employers providing health care insurance coverage to their employees, that the employer's share of the annual assessment be 40% with the employee's share equalling the remaining 60%.

For those employers not providing health care insurance to their employees, the employer's should be required to pay 100% of the annual assessment and be obligated to pay an additional 50% of the employee's first \$1,000 of hospital bills, annually.

The Hospital Association estimates that a combined annual payroll assessment of \$150 per employee (based on 1% of the first \$15,000 of earnings) would be sufficient to fund charity care services.

The implementation of a payroll assessment funding mechanism for hospital charity care services to the indigent could be phased-in over several years.

The following example provides for a four-year phase-in assuming that annual hospital charity care services continue to total \$560 million, statewide:

	<u>Payment Responsibility</u>			
	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>
Payers of hosp. care	\$420m (75%)	\$280m (50%)	\$140m (25%)	\$0.00 (0%)
Employer/Employee assessment	\$140m (25%)	\$280m (50%)	\$420m (75%)	\$560m (100%)

Insurer Responsibilities

Insurers play a major role in both payment for uncompensated care services and potential contributions to the production of uncompensated care services. If the trust fund is redefined to cover only the provision of charity care services with only the cost of bad debts being included in a hospital's rates, insurers must be required to calculate the resultant savings and reduce their insurance premiums, accordingly. These premium reduction calculations should be reviewed and verified by the Department of Insurance.

Insurers should also be required to identify their elements of costs supporting existing premium levels to subscribers by the following categories:

- Hospital Care
- Physician Services
- Drugs
- Nursing Homes
- Dental
- Insurance Company Administrative Costs
- Profit Margins

Insurers should also be required to meet timely claims processing standards and claims adjudication notification standards to both hospital providers and the insured.

As referenced earlier, insurers should also be required to participate in a statewide database of insured individuals for hospital inquiry to facilitate the identification of potential insurance coverage to both reduce bad debt and charity care services.

Conclusion

The New Jersey Hospital Association appreciates the opportunity to share these comments, concerns, and recommendations with you, the members of the Assembly Health and Human Services Committee. I would be glad to provide any additional clarification to our comments or answer any of your questions and again, our Association's staff or representatives from our member hospitals stand ready to provide any technical or anecdotal information that may be helpful to the Committee's inspection of this very important aspect of our New Jersey health care delivery system.

Thank you!



NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION

Statement

of the

New Jersey Business and Industry Association

before the

Assembly Health and Human Services Committee

by

Bruce G. Coe

on

Uncompensated Care Funding

March 5, 1992

Mr. Chairman and members of the Assembly Health and Human Services Committee, I am Bruce Coe, President of the New Jersey Business and Industry Association. NJBIA represents over 13,400 employers Statewide. I would like to thank you for this opportunity to present the views of the business community on the issue of uncompensated care funding.

NJBIA members are growing increasingly frustrated and angry over the soaring price of health care. These employers have identified health care costs as their number one concern for three years in a row according to the results of our annual Economic Outlook Survey. Health insurance premiums have been escalating an average of 20-25 percent for the past few years--with some companies even reporting increases of 50 percent. Fortunately, this onerous tax expires on June 30, 1992. Providing the greatest disincentive to either the initiation or continuation of health insurance, this 19.1% tax is by far the worst tax in New Jersey.

P.L. 1991, c. 187, introduced a number of new initiatives to reduce uncompensated care:

- Medicaid has been expanded to 185% of the poverty level for pregnant women and infants up to one year of age.
- 48 hospitals now have on-site Medicaid-eligibility workers to allow hospital-based enrollment of uninsured Medicaid-eligible patients.
- Insurers are required to offer an affordable insurance program emphasizing preventive services and costing approximately \$1,500 per year.
- Evening and weekend hours at nine community health centers were expanded as a result of an appropriation of \$10 million.

This expansion is expected to increase the availability of primary care to needy populations at hours of the day when their only source of health care is too often hospital emergency rooms.

- Partnerships between hospitals and community-based providers through the Competitive Initiatives Program will allow for uncompensated care previously provided by hospitals to be delivered at less costly primary care sites.
- HealthStart Plus will provide access to medical care for pregnant women and children up to age one year for families with incomes up to 300% of the federal poverty level.

UNCOMPENSATED CARE

Uncompensated care costs, funded through a 19.1% tax on hospital bills, have escalated at several times this rate in recent years. While the reforms I have just mentioned will serve to significantly reduce the amount of uncompensated care, there is also clearly a need to improve the collections process. In November 1991, all Chapter 83 New Jersey hospitals were required to submit a computer tape detailing demographic data about any patient whose account balance was referred to a collection agency or for legal action. This is the first industry-wide data base of this nature, providing information about New Jersey residents who have outstanding bills. Among the remarkable findings from this study:

- Sixty-four percent of the records had no employment information.
- Sixty percent of the bad debt had no employment data.

- For self-pay accounts of patients under 18 years of age, sixty percent (60%) of the records had no health care coverage information of the child's parents.
- For self-pay accounts of married patients, 67% of the records had no health care coverage information of the spouse.
- No monies were paid for inpatient or outpatient care by 47% of the clients.
- 73% of the records were for balances under \$500.
- 17% of the records were for balances between \$501 and \$2,000.

IMPROVED COLLECTIONS

I agree with Commissioner Dunston's comments in the February 1992 Report to the Governor and the Legislature concerning the New Jersey Health Care Trust Fund:

"Most importantly we need to provide greater incentives to hospitals to collect accounts before they ever become bad debts. Hospitals must exert greater efforts to get appropriate financial information before the patient leaves the hospital. There are still too many non-emergency situations in which the hospital fails to obtain insurance and employment information, two basic elements for a successful collection effort."

NJBIA applauds efforts by government to help acute care hospitals improve their collection process. Working with six vendors and 14 hospitals through May 1992, the Department of Health is studying how innovative collection techniques can reduce the amount of bad debt.

And in March 1992, the Department, working with collection agencies and attorneys, will attempt to collect bills that hospitals have determined to be uncollectible. During calendar year 1991, the first full

year of the SOIL program, \$17 million or 4.3% of bad debt was recovered from homestead rebates or State Income Tax refunds.

NJBIA supports the concept of government working with hospitals to help them collect bad debts. Certainly the expiration of the 19.1% hospital tax will provide an enormous incentive for hospitals to improve collections so that they may remain competitive.

COMPREHENSIVE REFORM

In an effort to address the overall problem of rising health care costs, NJBIA strongly supports comprehensive health care reform including an improved hospital reimbursement system, incorporation of managed care approaches in public and private plans, medical malpractice reform and addressing the rising Medicare cost shift. Clearly the "system" must be tilted more towards prevention and affordability. Of particular importance is small group health insurance reform, which will result in greater accessibility and affordability for companies of 25 or fewer employees. In addition, the removal of the 19.1% tax will remove one major cost factor for the small group and other markets. Legislation sponsored by you, Mr. Chairman, Assemblyman Felice and Senator Bassano recognizes the need for small group reform. NJBIA pledges to work with you, the Department of Health and the Department of Insurance to develop such insurance.

Although experience in other states has not been heartening regarding the purchase of basic plans by small companies, we are optimistic that with comprehensive reform the situation will be better in New Jersey. For one, NJBIA plans to be very active in promoting these plans to our membership, something which does not seem to be typical of associations in other states. Furthermore, according to a survey of NJBIA's small member companies last year, 89 percent of the respondents

currently not providing health insurance to their employees indicated they would be interested in doing so if affordable plans were made available. Seventy percent of the respondents identified affordable to be in the \$1,500-\$2,000 range.

Mr. Chairman, members of the Committee, the business community does want to participate in developing a health care system that allows access for all New Jersey citizens.

Thank you for the opportunity to appear before you today. I will be happy to answer any questions.

TESTIMONY

BY

MELANIE WILLOUGHBY

NEW JERSEY RETAIL MERCHANTS ASSOCIATION

&

MAUREEN LOPES

NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION

ON BEHALF OF

HEAL COALITION

(HELP ESTABLISH AFFORDABLE HEALTH CARE LAWS)

MARCH 5, 1992

ASSEMBLY HEALTH & HUMAN SERVICES COMMITTEE

**VALLEY HOSPITAL
RIDGEWOOD, NJ**

Mr Chairman, distinguished members of the Committee, I am Melanie Willoughby, President of the New Jersey Retail Merchants Association and Co-Chair of the HEAL Coalition. With me today is Maureen Lopes, Vice President for Health Affairs of the New Jersey Business & Industry Association and the other Co-Chair of the HEAL Coalition. We are pleased to have the opportunity early in the legislative session to come before you to lay out our thoughts on the Health Care Trust Fund and its component parts and to recommend our reform proposals to fix this broken health care system.

New Jerseyans are deeply concerned about health care costs and availability of health insurance. Health care costs are spiraling out of control. Medical care costs grew almost twice the rate of inflation between 1980 and 1990, according to the U.S. Department of Labor. In 1989 alone, expenditures for health care increased 11% from the previous year. Estimates are that 800,000 citizens in this state lack health insurance. The members of the HEAL Coalition joined forces in 1990 to pursue practical solutions to this crisis through comprehensive reforms.

HEAL (Help Establish Affordable health care Laws) is a broad based coalition of associations and businesses representing more than five million employees throughout New Jersey.

HEAL members include the National Federation of Independent Businesses, the New Jersey Business & Industry Association, the New Jersey Food Council, the New Jersey Restaurant Association, the New Jersey Retail Merchants Association the New Jersey State Chamber of Commerce, the Health Insurance Association of America, the New Jersey Association of Builders and Contractors, the New Jersey Commerce & Industry Association, the New Jersey Association of Temporary Services, and other concerned businesses, large and small.

We are here today to specifically address the Health Care Trust Fund. We would like to highlight three areas that are part of our prescription for health care reform that are germane to the reform of the Health Care Trust Fund.

*Incentives to hospitals to collect bad debt

*Demographic study of recipients of uncompensated care to be able to determine the type of solutions needed to address each constituency that uses the fund

*Small business underwriting insurance reforms

Since 1980, New Jersey has reimbursed hospitals for the entire cost of uncompensated care to ensure that its residents, regardless of their income or insurance status, had access to health care. Uncompensated care costs have grown from \$233 million in 1983 to an estimated \$654 million in 1990. This amount represents 9% of the total 7 billion dollar cost of hospital care in New Jersey.

According to the New Jersey Department of Health approximately 82 percent of the uncompensated care for which hospitals are reimbursed, is bad debt. A patient's bill may become bad debt because the patient cannot afford to pay, but does not qualify for charity care. Or, a patient with adequate resources may simply choose not to pay. It could be that the patient did not pay his copay or deductible.

The high percentage of bad debt cost inherent in the NJHCTF and the large number of New Jersey residents who use the fund are two major reasons for reform. One of the important first steps toward assessing the utilization and functioning of the NJHCTF was a study commissioned by the legislature in 1991 to demographically describe the users of the Trust Fund. The concern being explored is that the truly needy and truly uninsured are not the only beneficiaries of the Trust Fund. HEAL anxiously awaits the official release of this information, as it holds the key to reforming the NJHCTF.

HEAL believes that the Health Care Trust Fund is used by many constituencies that need to be identified through data collection of the patient records from the hospitals to determine exactly who uses the system, why and their ability to pay. Only after this determination is made can we really make any decisions about how to build programs that will address the needs of each constituency and help them out of the utilization of the Health Care Trust Fund.

HEAL's proposals go to the heart of the structural problems with the Trust Fund as a health care financing mechanism. Unfortunately, there are those who shy away from such real reform in favor of ever increasing reliance on additional funding. New Jersey does not have the fiscal luxury of throwing money at a broken, inefficient system of health care financing. HEAL believes that the proposed payroll tax to fund the Health Care Trust Fund is not the answer.

Reform is needed to reduce the bad debt and to reduce the cost of providing care to those without insurance. This can be accomplished by providing hospitals with incentives to improve their bad debt collection procedures and by allowing the NJHCTF to pay for care provided outside the hospital. In addition, there must be adequate policing of the users of the Trust Fund, to make sure only those intended are beneficiaries.

HEAL recommends:

SETTING STANDARDS FOR BAD DEBT: The Department of Health should assess the quality of each hospital's collection efforts. A standard should be determined for each facility using a statewide model which predicts a level of uncompensated care based on hospital characteristics, such as patient income-levels and insurance status.

IMPROVING COLLECTION PROCEDURES: Once a hospital's annual uncompensated care level is established, a hospital should be required to institute credit and collection procedures to assure that it will function within its established bad debt level.

HEAL believes that providing affordable and accessible health care coverage would be one way to get small businesses back into the insurance marketplace. This would provide the uninsured employees of small businesses with an alternative to utilizing the hospital emergency rooms as their primary care physician.

Small business (those with less than 25 employees) are in a Catch-22 regarding health care costs: they are especially vulnerable to increased insurance costs, but they also employ most New Jerseyans. Most small businesses want to provide health insurance for their employees, and nine out of 10 full-time employees currently have health insurance. However, increasing numbers of small employers can no longer afford health insurance or are no longer able to find an insurer willing to offer them a policy. In addition, due to irresponsible practices of some carriers in the small business markets, there is little predictability associated with small employer premiums.

The small group market is especially vulnerable to rate increases because of the higher administrative costs and the fewer number of participants over which to spread the risk. It is estimated that it costs about 30 percent more to market to small groups and to handle small group claims. And one catastrophic illness can cause a small group's premiums to soar because there are fewer subscribers to absorb the costs. Small businesses, like any other business or household, needs the ability to plan for their financial future. Stability in the market is key to controlling the problems with small group health insurance.

Additionally, New Jersey has enacted several laws requiring that health insurance policies cover specific diseases and services - mandated benefits. Requiring that all plans include these expensive state-mandated benefits, whether or not the benefits fit the needs of the particular employees, also adds to the cost of health insurance. It is also important to remember that self-insured companies are exempt from mandates by federal law. Those unable to self-insure -- mostly small businesses -- bear the brunt of these costly mandates.

According to The National Center for Policy Analysis, "regulation of health insurance by state governments is causing millions of Americans to be priced out of the health insurance market" and the imposition of mandatory benefits "reflects a desire on the part of state legislators to force private sector to pay for costs that would otherwise be paid for by government."

New Jersey did take an important first step in 1991 towards solving this problem, by enacting legislation that would enable payers to offer "basic"(meaning free from certain state mandates) health insurance policies. HEAL participated in good faith in the legislative negotiations on this package, with the understanding that the next steps toward comprehensive reform of the small group market, namely rating reform, guaranteed issuance to all small businesses, and reinsurance of high risks, would be dealt with in future legislation.

Rate stability can be provided to small businesses by eliminating costly mandated benefits and by reforming small group underwriting practices. Both aspects are necessary for the reform initiative to be successful.

HEAL recommends:

GUARANTEEING AVAILABILITY OF COVERAGE TO SMALL BUSINESSES: Employers with 25 or fewer employees should not be denied coverage, even if one or more of their employees or dependents might otherwise be uninsurable or a high risk. Once insured, neither the group nor any individual in the group should be denied continued coverage because the group's, or an individual's, health deteriorates.

LIMITING RATE SPREADS: There should be a maximum permissible spread between each carrier's lowest and highest rates for each class of business. Rating factors for industry, experience, and health status, which may be abused by some carriers, would also be severely limited under the HEAL proposal. These restrictions eliminate "blacklisting" of industries and pricing riskier groups out of the market.

LIMITING THE USE OF PRE-EXISTING CONDITION EXCLUSIONS: Some carriers today impose an exclusion from coverage for medical costs associated with health conditions which arise before the health insurance policy is purchased. Under the HEAL proposal, a limit would be imposed on the length of time a carrier could exclude coverage for a pre-existing condition, and insurance carriers could not impose new pre-existing condition exclusions on individuals covered in the small group market when individuals change jobs or employers change carriers. This way, changing jobs will not mean losing your health insurance.

ESTABLISHING A REINSURANCE PROGRAM: By guaranteeing issuance of insurance to all small groups at premiums limited by the above mentioned rating restrictions, the insurance industry is accepting more risk than it does currently. Under the HEAL proposal, small group insurance carriers would be permitted to reinsure eligible individuals and groups -- in essence buy another insurance policy on those likely to have claims which exceed the coverage provided by the premium. The reinsurance process would be handled privately to avoid discriminatory treatment and to protect employee privacy. Any employee whose coverage was reinsured would pay the same premium and receive the same benefits as other employees in the group.

In simple terms, reinsurance allows carriers to identify high risk cases and to purchase an insurance policy on those cases by paying a fixed reinsurance premium. The reinsurer, in turn would cover the costs associated with the carrier's reinsured individuals. This reinsurance, when coupled with guaranteed issuance, will allow carriers to accept risks that they might not normally accept. They are protected by the marketplace at large from accumulating a disproportionate number of high risk cases.

The reinsurance program is privately funded by the insurance industry. Participating insurance carriers would pay premiums for the reinsurance policies, and be assessed for reinsurance program losses. The assessment would be no more than 4 percent of the premiums the participating carriers receive from policies covering small employers. If the initial assessments prove inadequate, all carriers would be assessed up to 1 percent of their total health insurance premium. Importantly, assessments could not be passed along to small employers in excess of the restricted premiums.

This reinsurance program would not become the JUA of health coverage. Charges would be realistically set in relation to expected costs instead of being set artificially low. The reinsurance premium rates (500% of the normal premium rate if an individual in a group is reinsured, and 150% of the normal premium rate in an entire group is reinsured) would ensure that only very high risk individuals or groups would be reinsured.

MANDATE-FREE HEALTH CARE COVERAGE: Carriers should be allowed to market a true "basic" policy, such as was originally contemplated in the negotiations during the 1991 legislative session.

In addition, under the HEAL small group reform proposal, carriers in the small group market would guarantee to any small business in New Jersey, a choice of two plans, both of which would be free from state mandates. The "standard" plan would offer a benefits package similar to that enjoyed by large self-insured employers, who escape state mandates under ERISA protection. The "basic plan, would be a limited benefit package, similar to the "basic" policy, but more specifically tailored to the unique needs of small employers.

In conclusion, the HEAL Coalition is ready to work together with you and the Legislature to develop the reforms that are needed to bring down the costs of health care.

WHO PAYS HOSPITAL BILLS AND UNCOMPENSATED CARE

	<u>Medicare</u>	<u>Medicaid</u>	<u>Blue Cross</u>	<u>HMO</u>	<u>Commercial</u>	<u>Self-Pay</u>
Payer % *	42%	10%	14%	3%	25%	6%
Uncompensated Care %	Exempt	18%	25%	5%	42%	10%
Uncompensated Care Dollars **	\$0	\$135 M	\$187.5 M	\$37.5 M	\$315 M	\$75 M

* Source: New Jersey Hospital Association, January 1992

** Total cost estimated by Department of Health at \$750 million in 1992.

WHO USES UNCOMPENSATED CARE -- CHARITY CARE

Total Uncompensated Care 1992 estimated \$750 million

18% Charity Care

What is Charity Care?

Charity care is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals in New Jersey.

Who is eligible for charity care?

New Jersey residents who:

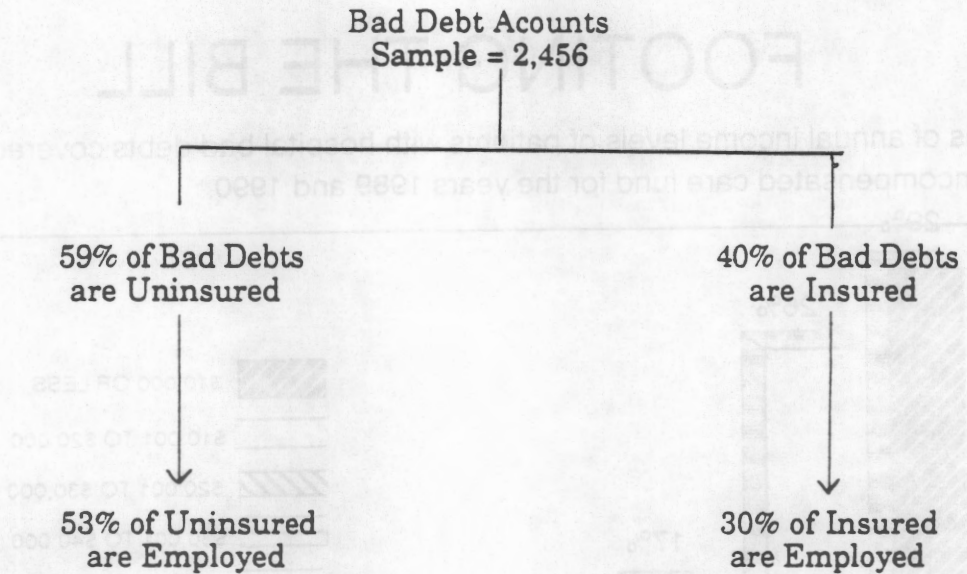
1. Have no health coverage or have coverage that pays only part of the bill; and
2. Are ineligible for any private or government sponsored coverage such as Medicaid; and
3. Meet both the income and assets eligibility criteria listed below.

<u>Income as a Percentage of Federal Poverty Income Guidelines</u>	<u>Percent of Bill Paid by Patient</u>
less than or equal to 150%	0%
greater than 150%, less than or equal to 175%	20%
greater than 175%, less than or equal to 200%	40%
greater than 200%, less than or equal to 225%	60%
greater than 225%, less than or equal to 250%	80%
greater than 250%	100%

WHO USES UNCOMPENSATED CARE -- BAD DEBT *

Total Uncompensated Care 1992 estimated \$750 million

82% Bad Debt



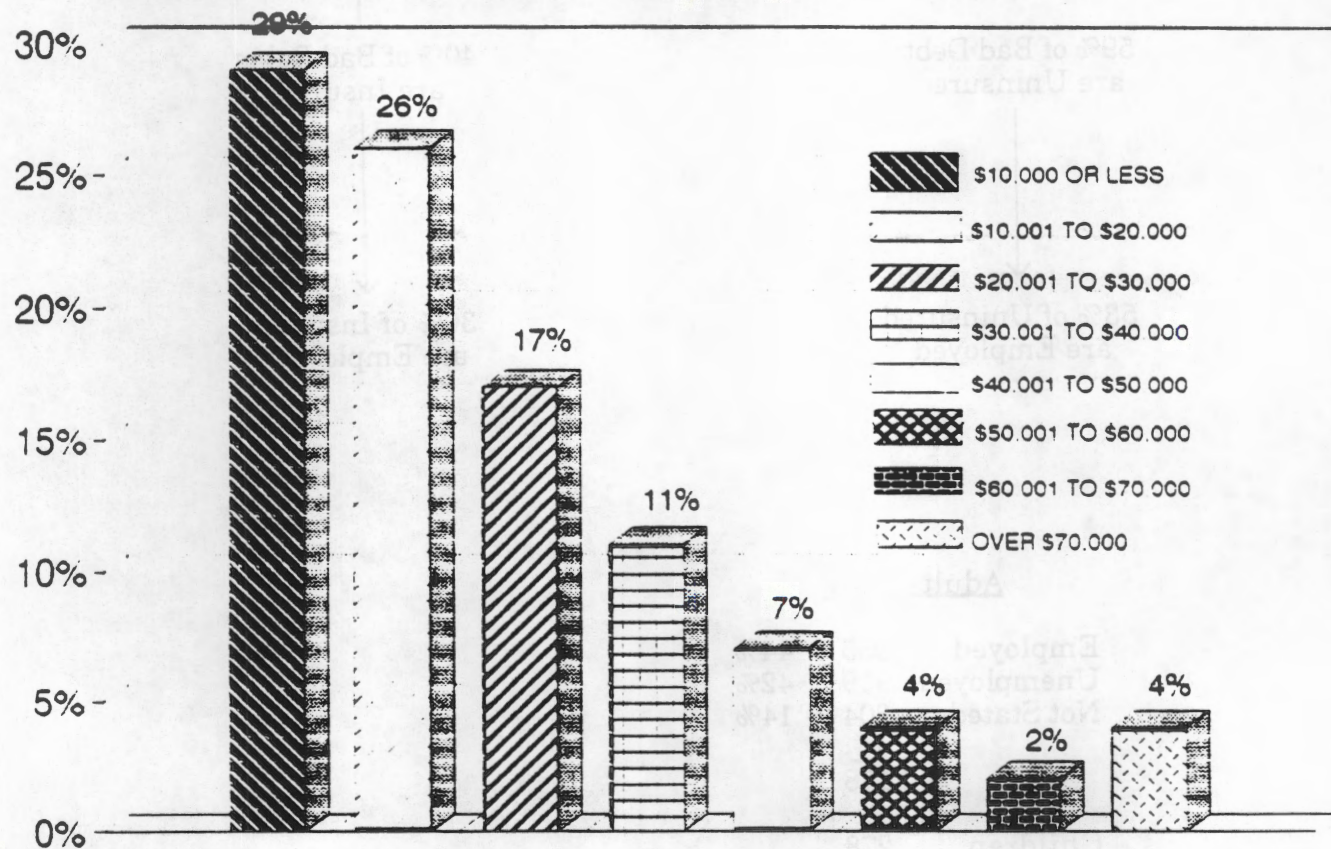
Adults Only

Employed	955	44%
Unemployed	919	42%
Not Stated	304	14%
	<u>2178</u>	
Children	278	
	<u>2456</u>	

* Source: "Uncompensated Care in New Jersey Hospitals: A Survey of Characteristics of Bad Debt Accounts", NJ Department of Health, December 1991.

FOOTING THE BILL

Analysis of annual income levels of patients with hospital bad debts covered by the state uncompensated care fund for the years 1989 and 1990.



Source: NJ Division of Taxation. Reported by Asbury Park Press, 2/2/92 by Sean McNaughton

January 1992

TALKING POINTS
SMALL EMPLOYER HEALTH INSURANCE REFORM

The New Jersey Small Employer Health Insurance Program is designed to make coverage available for any small group wishing to purchase it and to bring greater stability to the pricing and underwriting of small group health insurance coverage.

GUARANTEE ISSUE

Any small employer (25 or fewer full-time employees) applying to any carrier doing business in the small group market must be issued a basic health care plan.

In order to do business in New Jersey, all health insurance carriers, HMO's, Blue Cross and Blue Shield and other small employer carriers must issue a plan to any group which agrees to make the required premium payments and satisfy the other provisions of the plan.

GUARANTEE RENEWAL

A basic health care plan cannot be cancelled where a group has experienced a serious illness. Policies are renewable except for nonpayment of premiums, fraud and non-compliance with participation and contribution requirements.

SMALL EMPLOYER HEALTH REINSURANCE PROGRAM

The cost and risk of covering high-risk groups and individuals is spread throughout the industry by means of a reinsurance mechanism. Spreading the cost and risk protects the solvency of those companies which issue products with a guaranteed issue and guaranteed renewability feature.

Participation in the reinsurance mechanism is voluntary. Small employer carriers can choose to either reinsure high-risk individuals and groups with the reinsurance facility or to assume all risks and costs internally.

Losses would be financed by the health insurance carriers. First, losses would be spread across carriers in the small employer market through an assessment of up to 4% of premium. If, in a given year, losses were not fully absorbed by the small employer market, a second tier of losses would be spread more broadly.

Will the Small employer Health Reinsurance Program become like the New Jersey J.U.A.? No. The reinsurance program is designed to be attractive only for carriers to reinsure truly high-risk groups and individuals. The J.U.A. attracted far too many insureds into its inefficient bureaucratic system, largely because the J.U.A.'s premium rates were held artificially low.

PORTABILITY

Individuals who change jobs or coverage are protected from preexisting condition exclusions if they had satisfied such an exclusion under their prior plan.

All small employer health benefit plans are required to credit the time a person was subject to a preexisting condition exclusion under a previous plan if the coverage was continuous to within 90 days of the effective date of the new coverage.

ANNUAL RATE INCREASES

No group's annual premium rate increase may differ by more than a specified amount from the increase for similar groups.

The rate increase for any group may not exceed the percentage change for the carrier's lowest rate for a group with similar characteristics by more than 15% annually. This cap would limit adjustments for any particular small group's claim experience to 15% above the rate adjustment for all similar groups.

RATE CONSTRAINTS

No group's rates may vary from the average rate for a similar group by more than a specified amount.

The premium rates charged to any group may not vary by more than 22.5% above or below the average premium rate for similar groups with similar coverage.

AFFORDABILITY

Affordability of all small employer health benefit plans is enhanced by eliminating state-mandated benefits. No law may require reimbursement of a specific category of health care practitioner, or coverage of a specific health care service or benefit.

PRICE COMPARISON

Every small employer carrier will be required to offer one of the approved small employer health plans which will include managed care features to contain costs. In addition to managing costs, employers will be able to price shop in a market among plans with the same benefit coverage.

