PUBLIC HEARING

before

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

To Examine Access to Health Care in New Jersey

April 16, 1990
Woodbridge Public Library
Woodbridge, New Jersey

MEMBERS OF COMMISSION PRESENT:

Assemblyman James E. McGreevey, Chairman
Assemblyman Nicholas R. Felice
Assemblyman Neil M. Cohen
Assemblyman Anthony Impreveduto

ALSO PRESENT:

John J. Fay, Jr.
Special Advisor

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

* * * * *

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

New Jersey State Legislature
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
STATE HOUSE ANNEX. CN-068
TRENTON. NEW JERSEY 08625-0068
(609) 292-1646

April 2, 1990

NOTICE OF A PUBLIC HEARING

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

Monday, April 16, 1990
Beginning at 10:00 A.M.
Woodbridge Public Library
Main Meeting Room
George Frederick Plaza
Woodbridge, New Jersey

The Assembly Health Care Policy Study Commission will hold a public hearing on Monday, April 16, 1990, beginning at 10:00 A.M., in the Main Meeting Room of the Woodbridge Public Library, George Frederick Plaza, Woodbridge, New Jersey to examine problems relating to access to health care in the State. The focus of the hearing will be the availability of health care insurance for both employed and unemployed persons, including the determination of existing health care coverage among New Jersey citizens.

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

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

*****

ymb: 1-86

ASSEMBLYMAN JAMES E. McGREEVEY, (Chairman): Good morning and thank you for joining with us on the outset for the Assembly Health Care Policy Study Commission. Assembly Speaker Doria saw the need for the creation of such a Commission to begin to develop a cogent State agenda for health care, and the charge of this Commission is to focus on three basic areas.

First, we'll be looking at the entirety of the question of the dilemma of the Uncompensated Health Care Trust Fund, in conjunction with looking at and discerning the need for comprehensive health care coverage. We'll be looking towards also, the questions of Medicaid eligibility, Medicaid registration, and broadly based, we'll be looking at the entirety of the problem, the uncompensated health care and the lack of funding for health care coverage for New Jerseyans. In fact, as most of you recognize, there's over one million New Jerseyans without any type of health care insurance. So what we'll try to do on the outset, is focus in on the question of health care benefits, how it impacts the Trust Fund, and how it impacts the health care delivery service system in this State.

The second phase we'll be looking at is the question of DRGs, the prospective payment system. We've all seen the articles both in a number of State newspapers that reflect the problem with DRG as a prospective payment system, the problems of mark-up reconciliation reimbursement, and the inability of both the hospital community and the insurance community to accurately rely upon the DRGs as an intelligent, and in fact a prospective, payment system.

The third area that we'll be looking at will be the question of long-term health care; catastrophic health care. The questions, both in light of the AIDS crisis, and also in terms of the aging population in New Jersey. How do we provide community based services for elderly? How do we provide community based services for those that need not be in an acute care facility setting?

So those will be the three distinct areas. If I can, again: health care coverage and the question as it relates to the Uncompensated Health Care Trust Fund; the second area will be that of DRGs and how the DRG works or doesn't work, as a prospective payment system; and the third area we'll be looking, at the question of long-term health care and community based alternatives to the acute care facilities setting.

Today we're going to begin the first of what will be five hearings on that initial topic, and frankly what we're trying to discern today is--- both as the Pepper Commission has done on a national basis-- We are going to try to research and discern who has health care and who doesn't have health care at today's hearing. Broadly based, we're interested in not only the numbers of who has and who doesn't have health care, but the impact that has both in terms of insurance, and both in terms of also the hospital and hospital providers, as well as fundamentally, the citizens of this State.

With us, serving on the Commission, will be former Senator, former Ombudsman, Jack Fay. Jack, would you like to say a few words?

J O H N J. F A Y, JR: Only I think that the timing for this Commission on a statewide level, couldn't have come at a better time -- as recently as this morning's paper telling you that another major boost coming in on the home health insurance, the perfect timing of the Pepper Commission after much agonizing in Washington and hiding down there behind-- We can't afford this cliche, "the Pepper Commission is making a major recommendation." Supposedly from the people we hear from in Washington, that legislation will be coming down in May or no later than June, so it is ideal.

I think everything we can find, everything we can document in the statewide study, is only going to bolster the major move, both on the State level and particularly on the national level.

ASSEMBLYMAN McGREEVEY: Thank you, Jack. Also joining with us will be the members of the Committee, Anthony Impreveduto, Bob Menendez who's on his way, Jackie Mattison, Neil Cohen, and also John Kelly and Nick Felice. Nick?

ASSEMBLYMAN FELICE: Yes, if I may, I'd like to actually thank the speaker for getting this type of a task force hearing underway. I think one of the most important things facing New Jersey, and our country, is health care costs.

Recently, I met with 34 other states discussing health care in the United States, and it's really distressing to know that some of the states already have started rationing of health care. So you can see what it's doing to business and individuals alike. I have letters from my constituents, and some of the increases have been astronomical. With New Jersey being only second to Florida with the largest amount of senior citizens in the country, and with our population growth that we have -- and the fastest age group growing in the United States is 80 to 85 years of age -- you can see what it means to our elderly, our handicapped, our young people, and our people just starting off as married couples.

I think one of the most important things that we as legislators have to face in the years ahead, is health care, and I think that this is an excellent start to have this type of hearing. Thank you.

ASSEMBLYMAN McGREEVEY: Thanks, Nick. And I'd also like to note the able presence of Robbie Miller from the Office of Legislative Services and Kelly Ganges from the Assembly Democratic Office and I'd also like to thank Lou Metina, Michelle Sevileski, I'd like to thank Herb Gilsenberg and people from my staff for helping coordinate this effort. At this time it gives me -- it's an esteemed privilege to welcome the Commissioner of the Department of Labor, Raymond L. Bramucci.

COMMISSIONER RAYMOND L. BRAMUCCI: Good morning, Mr.Chairman, Neil Cohen, Jack, Tony, Nick. It's good to be here. Thanks for the opportunity to talk to you about what I consider to be one of the most critical issues confronting the State of New Jersey today. I commend you for taking on this very complex and difficult task. It is a task that must be taken on, however, since it is clear that current health care policies are not working. In fact, they have created inequities and distortions in the marketplace that are becoming intolerable and cannot be allowed to continue.

Let me begin by addressing the matter of health insurance coverage for those in the work force. Though available data are fragmentary and somewhat dated, they do enable us to sketch out a general profile of those who have insurance protection and those who do not.

The good news has been that the vast majority of adult workers in New Jersey have had at least some kind of health care protection, either under insurance plans provided at the work place or through policies purchased directly by the workers. According to a Department of Health analysis based on U.S. Census Bureau household survey data, about 89% of the State's employed workers aged 18 to 64 had coverage in 1986.

This finding is reinforced by the U.S. Bureau of Labor Statistics surveys of medium to large business establishments conducted at various times from '86 to '88, which reveal coverage rates for full-time workers, ranging from 91% in the Newark metropolitan area to 95% in Mercer County and the Bergen/Passaic County region. Most of these workers were protected by major medical coverage in addition to basic hospitalization and surgical benefits. In the large majority of cases, this coverage was fully paid for by employers.

The other side of the coin is that about 11% of New Jersey's employed workers aged 18 to 64 were without health

care protection in 1986. I expect that this figure has grown substantially between then and now.

Historically, gaps in health insurance protection were most common among young workers, those who work part-time and the working poor who earn too much to qualify for Medicaid, but too little to afford health insurance. Workers without coverage, who account for about 65% of all uninsured persons in the 18 to 64 year age group, were most heavily concentrated in the smaller service and retail establishments where employer-financed coverage is considerably less prevalent. Since these are the sectors where jobs have been growing most rapidly, there may well have been an increase in this percentage of workers without coverage since the Health Department study was done.

I believe this to be so, and I'll just add, apart from my prepared remarks, that there's been a surge in temporaries and agencies that provide workers for on-job sites. This destroys it further erodes -- at least the relationship between the work place, the paycheck, and the State -- our ability to deduct, and the ability of the employer to deduct for coverage. This is a considerable issue that we are now studying in our Department -- the growth of temporaries and consultants, the job agencies that provide workers on a temporary basis, what effect that has on medical insurance, and those who have it and don't have it.

Though a majority of workers enjoy some kind of health care insurance while employed, their situation can change dramatically if they become unemployed. Workers unemployed for a short period of time may remain covered by their employers' plans, but after a month or so, most of them will have lost their employer-financed protection. COBRA enables them to continue their group insurance for a while at their own expense, but few rank and file workers can afford today's sky-high premiums. Unless they can be covered by the insurance

of a spouse, many jobless workers soon find themselves without protection.

A survey of unemployment insurance claimants conducted by my Department in '86 revealed that only 52% of them were protected by health care insurance, despite the fact that many had been unemployed for only a short period of time and were still covered under their employers' plans. About 76% of the same sample of claimants had been covered by some kind of insurance prior to their layoffs. The loss of coverage would, of course, have been much greater if the survey had excluded those on short-term layoffs.

These and other gaps in health insurance coverage represent an obvious problem for 800,000 or more New Jerseyans who lack protection, as well as for health care providers and the public at large. It is a problem across the country that ideally ought to be addressed in a comprehensive manner at the national level. Having served at the national level for 11 years, I don't think there's any danger that anything is going to be done there. We cannot wait for that, however. We have been forced to deal with it at the State level and, unfortunately, we have not been doing a very good job of it.

I expect that Governor Florio's intention to establish a Commission on Health Care in the State will, in cooperation with groups like this one, begin to point the way to a much more effective means of addressing this most complex problem.

The most glaring example of our present failure is the manner in which we are financing uncompensated hospital care. I applaud the compassion of a State that makes it possible for anyone to obtain hospital care without regard to their ability to pay. It makes no sense to me, however, to dump the cost of indigent care on employers and individuals who have had the foresight to purchase health care insurance. We all know that the practice is to levy an assessment on the bills of those people who have the luxury of coverage and use it to pay for

those people who don't. Now I'm not sure that we ever debated this issue, or decided it in a formal way. We just kind of backed into it, and it's an item that is taking a larger and larger share of the medical cost pie.

In my town of Bergenfield, health care costs went up from 1989 to 1990, 27%. We're not talking about additional coverage, we're talking about hospital and medical care for covered workers, and I suspect throughout the State that this is a tremendous inflationary item in the State budget and local community budget and county budget -- the uncontrolled cost of medical insurance.

As you know, the uncompensated care surcharges have accelerated what was already a steeply rising trend of health insurance costs. This has prompted many employers to reconsider the kind of health insurance protection they are willing to provide as a benefit to their employees. Workers are being asked to absorb an increased share of health care costs.

As a result, disputes over health care benefits have become the single biggest issue in collective bargaining. I believe that in the recent period somewhere in the neighborhood of three-quarters of these labor disputes have focused on health care benefits as the central concern of both employers and employees. The recent NYNEX strike is but one of these disputes. In actual numbers, 78% of the strikes in our country in 1989, were out of medical cost related disputes -- 78% of those strikes.

The absurdity of New Jersey's uncompensated hospital care program is that it is worsening the very problem it was created to help overcome. Responsible employers are increasingly unwilling to subsidize the medical costs of workers who have not been provided protection by their employers -- central issue. If you're going into business, and you see the cost of medical insurance, you'll find a way of

either compensating somebody, and expecting that they cover themselves, or do something else, like get an inferior plan that really doesn't hold up, and then people who have first class insurance end up paying the bills of those who don't. More and more of them will be driven by competitive pressures to reduce or discontinue their medical benefits. This will increase the cost of uncompensated care, push insurance rates even higher, and set off another round of cutbacks in coverage.

Though it is clear to me that the current financing of our uncompensated hospital care program is both a fiscal failure and a potential deterrent to expansion of the New Jersey economy, I recognize that there is no easy answer to this problem. I am confident, however, that the dialogue this Study Commission has set in motion will point the way and, with the Governor's Commission on Health Care in the lead, such efforts will ultimately result in a workable solution. If there is any way that my staff and I can be of further assistance, please call on me.

ASSEMBLYMAN McGREEVEY: Thanks, Commissioner. I just have a few questions.

COMMISSIONER BRAMUCCI: Sure.

ASSEMBLYMAN McGREEVEY: You discussed briefly about the nature of health care as a critical question in labor negotiations. I would think obviously, those with health care -- those companies with health care, especially those organized labor fields with health care -- are put at a competitive disadvantage in the sense of the cost coming upon them by coverage of health care, relative to those who don't have any health care.

COMMISSIONER BRAMUCCI: I think, absolutely, Mr. Chairman. The number that's most frequently bandied about in the cost of covering a worker for Blue Cross Blue Shield, is somewhere in the vicinity of $3000 or $3500, but if one doesn't know what kind of ball game we're talking about -- since

they're always challenging the base for the rates -- but let's say $3000 and going up.

It's obvious that that is a tremendous knot before the first dollar is turned over, that an employer has to face, and ironically, when an employer requires a worker to pay a little more of the first $100 or the first $200, it may even be futile, since what may be driving that is not use of the system, but the hidden costs that are being paid.

I think the Uncompensated Care Fund has gone up tenfold in four years. This is a tremendous pool of costs that those people with coverage are asked to bear.

ASSEMBLYMAN McGREEVEY: Thanks, Ray. Jack.

MR. FAY: Commissioner, is there a millennia? I mean, is there -- when we're dealing with the status quo and being very very obvious, the inadequacy, the injustice, in many cases cruelty of just cutting people off. What is the millennia? What is some possibilities, if not probabilities, either on the Federal level or on the State level that we could be suggesting?

COMMISSIONER BRAMUCCI: I think, Jack, we can learn from the past, that in New Jersey, we have the resources to solve knotty problems. There are two instances in the past that I can point to that give me hope.

Twelve or 13 years ago, New Jersey had the worst worker's compensation systems in America. It had the highest premiums for employers. We had the lowest pay out to workers, and a commission got together -- much in the same way as we're beginning to kind of feel our way now, of responsible labor and management in the community and providers -- and worked out a system wherein seven of those years that have ensued since the time that the change was made premiums went down, paid by employers.

The average claim went up dramatically, so that people who are truly injured got paid commensurate with their loss, rather than a little bit because we gave something to

everybody. And we cut the number of claims dramatically, so that the little negligence things didn't find their way to the court -- now, that's one example.

We had an unemployment insurance crisis in the late '70s where the State of New Jersey -- I was a labor official then -- owed the Federal government nearly $800 million in loans, to pay for the extended benefits that we had in the slowdown times where we're suffering recessions. Again, responsible elements of the community got together-- Look, there's some good news and bad news in the process of changing that for the better. There are people who are going to have to pay what they're not paying now. There are others who would be released from that owners' burden, but it's possible, in the interest of the community, in the interest of the greatest good for the greatest number, to put together a group of New Jerseyans to solve this problem -- "'cause the Federal government ain't gonna do it."

ASSEMBLYMAN McGREEVEY: Neil.

ASSEMBLYMAN COHEN: Commissioner, in terms of incentives for small businesses to provide health care coverage for their employees, is there any tax mechanisms, tax credits? Some incentive that could be utilized to-- Even though the cost of health care insurance may be high, perhaps it could be reduced by small businesses who are large enough to have a group plan, but don't want to provide it because of the cost, but perhaps incentives could be utilized to provide them with tax benefits, tax credits?

COMMISSIONER BRAMUCCI: I wouldn't rule that out, Assemblyman. I think that in the mix of the medicine that we're going to have to bring to bear on this problem, that is an avenue. Since it was simply announced, in a kind of draconian edict, that everybody has to have insurance, that's easy said, but they've already tried that in the Soviet Union and it didn't work. You know, they're trying to get to what

we're doing. So, you've got to find a way to keep people in business while bringing to the real public floor the responsibility of those employers to carry some sort of insurance, so that the marketplace isn't as skewed, and you have basic fairness, and people who are running up the costs are paying them. Right now, we don't have that.

One other observation I'd like to make, Mr. Chairman, is that in the last session of the Assembly -- I don't believe it's the last one or the one before -- there was an attempt to provide medical insurance and life insurance for unemployed workers. I think that is a bonafide issue, than for providing insurance for unemployed workers who've never had it, because we cannot set up a situation in the State of New Jersey where we have a benefit for being unemployed, that you don't have for work.

ASSEMBLYMAN FELICE: If I may? Commissioner, we've gone through this for the last four or five years -- different methods of those people that are unemployed who have been working and received unemployment checks. There's been legislation on both sides of the aisle to say that that should be part of the monies that are taken out of their unemployment check to insure because the problem that you have is that those people that are unemployed that say, "Well, I don't need health insurance for awhile, I'm going to get a job in a month, or two, or three," and during that period of time if they should get sick without either taking the option to pay on their own-- And that's a large force of people who are, in the interim between skilled and unskilled jobs, that are unemployed and receiving unemployment compensation and yet, not having any coverage.

The problem that we have -- first of all with the DRG, the uncompensated care -- is, how do we during the interim take care of those people, those hospitals, in the urban areas? How do we give them the kind of coverage so that those hospitals do

not close down as they have in other states? What do we do to ensure that those people who need that basic coverage-- We're not talking about any blue ribbon health care coverage, but the basic medical coverage that those people need to survive.

The problem that you have with young people and old people alike, is they will cut down on the basic care, and if a small business has to give some kind of health care, aren't they going to give the barest minimum, which in a sense is not going to cover any major illnesses? I think that's the thing we're heading for. I think we have to look as a State and a country-- Are we looking for a national health care program? Are we looking for socialized medicine? Which direction are we going to ensure that our young people, who many times are the biggest offenders in the sense that they do not figure that they're ever going to get sick and need health care, which is naturally a fallacy-- And with our growing elderly population, and our veterans in New Jersey alone, this is a problem that we all have to face.

In local areas in my county -- in one of my two counties -- you see budget proposals. They're not concerned about increases in salaries. The biggest increase in one of my communities is 47% in the health care, so the tax budget is not how many raises they're giving to the police or DPW, it's health care. So what do we do in the interim? How do we help in one way or another to get small businesses and others to be able to cope with the problems of getting the labor that they need -- and we do have a shortage of labor in certain skilled and unskilled areas -- to keep those people, and yet let the small business be able to provide that health care? I think we need not only on a State level but on a Federal level too, direction.

COMMISSIONER BRAMUCCI: Well, we can petition, but as I said earlier, realistically there's nothing on the agenda that would suggest that anything is even close to movement in

the Federal government. How should we proceed? Very carefully in our own State; very carefully. That's the point that I'm making with unemployed workers who have lost their benefits, who once had it, and those who don't have it, and would get it under certain schemes. I'm not saying don't do it. I say be very careful about how we cover people in our places of work.

According to the AFL-CIO, 41% of the people whose bills were paid by the Uncompensated Care Fund, were employed. An additional 25% to 30% of those had dependents who also had their bills paid. So you're talking about the majority of people whose bills were paid for by the Uncompensated Care Fund who are employed. So short of that draconian edict that you've got to have medical insurance if you're in business -- because that would clearly be a tremendous imposition on small businesses just flat out -- but we've got to get at this, and what I'm suggesting to you, Mr. Assemblyman, is that this Committee, the Governor's Commission, we have done important work in the past of rectifying very serious problems.

I think we have the kind of community of people, of labor and people in industry, and people in the professions who can sit down and coolly and calmly and carefully work this thing out. It may be a little medicine that we've got to put a little sugar with to go down, but it has to be done if New Jersey's going to prosper. This is a situation that's getting worse and will consume us.

ASSEMBLYMAN McGREEVEY: Assemblyman Impreveduto.

ASSEMBLYMAN IMPREVEDUTO: Yeah. Ray, you had mentioned, and the thing that worries me -- and it really does worry me -- is the fact of the people not covered by health insurance who are currently employed, will grow, and it is growing, and will continue to grow by leaps and bounds. We talk about $3000 for a health care policy for a single person, let's talk the realistic: It's a family policy and that's anywhere from $6000 to $8000.

And when you have a company like Bell Telephone now -- I think next year their employees of one of the strikes, as you mentioned with NYNEX, was over health benefits. I think next year they go on to pay their own benefits. The thing that worries me, is that people like that will begin to drop out of the system. Now what happens? Where is it going to end?

The cost of the care is going up. The small businesses, as was said-- The mom and pop grocery store can't afford $8000 for a year for a Blue Cross/Blue Shield policy. Our senior citizens who are looking to get Blue Cross/Blue Shield as supplemental coverage to their Medicare, are finding now that it's going beyond their reach. It's scary. I don't know where we're going to go with it?

COMMISSIONER BRAMUCCI: Well, we've got to go somewhere with it, because right now we're drifting. What we have now, is we've backed into a health care policy that no one really sat down and discussed fully. It's one thing if you design a scheme that doesn't work and have had full participation of everybody in the picture -- those who have coverage, those who don't, the poor, the destitute, the aged, the young. We haven't had any kind of meeting and get-together that I know of in the past history of New Jersey. We simply drifted into this policy.

What we've got to do is to find a way to be equitable, without being rash and irresponsible. The New Jersey economy is healthy, basically. We have an intelligent population. We have to define the general interest. We have to figure out what it is we have to do to keep the State on an equal footing industrially and economically and yet be not unmindful that people do get sick and go to the hospital, whether they have medical insurance or not.

Now I'm not aware that the Bell people are paying their own insurance--

ASSEMBLYMAN IMPREVEDUTO: Not this year, next year.

COMMISSIONER BRAMUCCI: I'm not aware that they're ever going to pay their own insurance, they're paying a little more of the copayment, but it's not fair to say that they are paying their own insurance.

ASSEMBLYMAN IMPREVEDUTO: No, I was under the impression that they were.

COMMISSIONER BRAMUCCI: That's the traditional thing that employers have done. Instead of getting your bill paid for from the first dollar, you pay the first $100 or $200. That's what that issue is.

ASSEMBLYMAN IMPREVEDUTO: Ray, just another question if I can, and a little story with it. I had a call to my office about a month ago -- a little longer maybe -- from a gentleman who is blind and operated a little newsstand in one of the courthouses in Bergen County. He didn't make enough money to pay for health care insurance. He had a family, a wife and a child, a three-year-old child, but yet the money he made was $1000 more than he could get to get coverage for his family through--

COMMISSIONER BRAMUCCI: Medicaid.

ASSEMBLYMAN IMPREVEDUTO: --Medicaid. His infant son -- three-year-old son -- became ill and the wife took him to a doctor. The boy needed some kind of surgery and would cost $1000, up front. They called me and finally we worked it out where the doctor said, "I won't charge you, but the hospital wants $1000 up front." I called Ollie Baldwin -- and he's back there -- who certainly was willing to help, and I'm sure we could have wiped out that $1000 up front for the hospital through his office. Eventually, the situation was taken care of by Stanley Bergen at the University Hospital.

Here's a person with a three-year-old son, and the doctor said, "The kid's in pain, take him home and give him Advil, or Tylenol," -- or whatever you give a child -- "and give him cranberry juice"-- The kid couldn't urinate. A

three-year-old child. When I look at situations like that, my stomach turns. What does a person like that do? Do they go to the hospital and say, "Take my kid anyway"? What do you do?

COMMISSIONER BRAMUCCI: You do what they did.

ASSEMBLYMAN IMPREVEDUTO: Yeah, well fortunately, someone else called me and I got involved, but those who don't know how to do that or don't think to do that, where do they go? What do they do?

COMMISSIONER BRAMUCCI: Well, there's always that-- We have a gap in the safety net and that gap is between Medicaid and presumably, the poverty level. We've tried to stretch it from time to time, but that's also money. That's cost. That's part of the mix that we're talking about here. It's clear that you don't want a three-year-old acutely ill child to go around begging, and luckily you had a good Assemblyman who knew where to call and what doors to knock on and he got things squared away. It is absurd, but that's the system that we have. We have a makeshift system that is basically creaking and not working, and that's an anecdote that's sad.

Hopefully, it was ended all right, but what we've got to decide here, is how as a State, we're going to pay the bill of medical costs that are going to come up -- whether they're for the three-year-old little boy, or the aged person, or the youngster working on a construction job for cash? How are we going to pay that bill? I say, that it's not fair to have the GM workers pay for it, the NYNEX people pay for it, and others who are in business and providing that coverage.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Commissioner. Any other questions? (no response). Thank you very much for your time.

COMMISSIONER BRAMUCCI: Thank you very much.

ASSEMBLYMAN McGREEVEY: Ray, would it be possible for us to have a copy of your comments, and a breakdown of the

percentages that you had on uninsured workers?

COMMISSIONER BRAMUCCI: I'll get it over to your office today.

ASSEMBLYMAN McGREEVEY: Okay. Thank you.

COMMISSIONER BRAMUCCI: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you for your time. The next person that will be testifying will be, Mr. Michael Siavage, General Counsel, Blue Cross/Blue Shield.

M I C H A E L S I A V A G E, ESQ.: Thank you, Mr. Chairman. Mr. Chairman, Assemblymen, members of the staff, Mr. Fay, Blue Cross and Blue Shield welcomes this opportunity to testify before you this morning on the very important issues at which you're looking. It is our hope that the establishment of this Assembly Study Commission is a step toward our State coming to grips with the burgeoning crisis in both health insurance and health care financing in New Jersey.

BCBSNJ provides health insurance to over 3.3 million people in New Jersey, and for nearly 60 years BCBSNJ has been the dominant force in health insurance in this State. As a corporation we are proud of our record of achievement and look forward to retaining our position as the preeminent health insurance for New Jerseyans into the 21st century. Our accomplishments and tradition of service to the residents of New Jersey speak for themselves.

Yet today the health insurance industry, including BCBSNJ and the health care system in New Jersey and our nation finds itself at a crossroad. Perhaps never before have the interrelated issues of accessibility, affordability, and quality of care been more in the public eye. The issues facing this Commission are different one; at times the problems of the system seem intractable, yet at BCBSNJ we believe that there are programs and policies which can be adopted on both a short-term and a long-term basis which can make health

insurance and access to health care more affordable and available to New Jerseyans.

In considering the issue of the availability of health care, this Commission should be aware that throughout the United States, other states are wrestling with the same problem. Several have initiated programs aimed at addressing this issue; it is possible that some of these initiatives could be tailored to fit the needs of New Jerseyans. In evaluating other states' proposals, however, this Commission must recognize two things: 1) the unique nature of the hospital financing system in New Jersey, and 2) the special role that BCBSNJ plays in that system.

Blue Cross and Blue Shield of New Jersey provides a unique service to the residents of New Jersey. It performs a function not provided by any other health insurer in this State. At BCBSNJ, any resident of the State of New Jersey can purchase health insurance, at any time, regardless of health; no one is ever denied health coverage when they apply to BCBSNJ. Our position of continuous open enrollment is in sharp contrast to the practices of commercial health insurers which market non-group policies to only the most insurable members of the public. Even using this selective approach, several commercial insurers have withdrawn or are contemplating withdrawal from the non-group marketplace today.

It is becoming increasingly difficult for BCBSNJ to perform its statutorily defined role as the insurer of last resort for New Jerseyans. Health care costs continue to rise faster than prices generally. In 1989, BCBSNJ health care costs increased at a rate of 23%, compared to an estimated 4.8% for the consumer price index.

The cost of health care has skyrocketed for many reasons including: 1) new medical technology, 2) increased hospital costs, 3) increased utilization as the population ages, 4) rising malpractice costs, leading to the practice of

defensive medicine, and others. These factors are driving health care costs up throughout the United States. But exacerbating the problem in New Jersey and contributing directly to the high cost of health insurance is the problem of cost shifting via the existing hospital finance system.

The ultimate impact of reimbursement of uncompensated care and government cost shifting on health insurance premiums can be illustrated by the fact that approximately $.30 of every $1 of hospital premium BCBSNJ collects, pays for the care of someone other than our subscribers. As the following statistical information illustrates, the impact of cost shifting has been devastating to BCBSNJ's customers. It is especially disturbing that the size of these cost shifts has been increasing so rapidly.

If you'll permit me, members of the Commission, there is in my testimony a chart. But to sum it up, uncompensated care, statewide, in 1985 presented us with a cost of $281.1 million. As you can see, in 1989 that rose to $686.3 million and is estimated to rise to $1.1 billion dollars in 1990. Likewise, BCBSNJ's portion of those costs, that is the portion of the costs shouldered by BCBSNJ customers, has risen from $49.7 million in 1985, to $243 million in 1989, and $394.5 million as an estimate in 1990.

The New Jersey hospital finance system has achieved the goal of providing access to hospital care for the uninsured in the State of New Jersey. Under the existing system, the insured have not been denied admission to New Jersey's hospitals, and hospitals have been given a means to finance the cost of care provided to the uninsured. Still, achievement of this goal has not been accomplished without cost -- as can be seen -- and that cost has been higher health insurance premiums for all purchasers of health insurance.

At the end of this year the Uncompensated Care Trust Fund will expire. It is highly probable that there will be

legislative initiatives to renew or replace the current system of financing uncompensated care. It is our hope that the Legislature, led by this Commission, will examine the existing methodology and look for ways to improve the system. The cost and availability of health care insurance is intrinsically tied to the existing health care finance system. If improvements are made to that system, health insurers and their customers will benefit from these changes.

This is not the first time that the Legislature has studied the problem of affordability of health insurance. In 1988, as part of Blue Cross and Blue Shield of New Jersey's restructuring legislation, the Legislature created a Study Commission to Study Health Service Corporations. BCBSBJ is the only health service corporation operating in the State of New Jersey. Among other things, that Study Commission was charged with studying the question of how best to provide insurance coverage for high risk individuals. Prior to its expiration, the Study Commission issued two reports to the Legislature. BCBSNJ was a member of that Commission and endorses the recommendations that it made. The members of this Study Commission might wish to review the finding of this prior study to determine if any of its suggestions might merit further consideration.

The report issued by the Study Commission is quite lengthy. For the purposes of this hearing, it may prove useful to consider several of its recommendations which focused on making health insurance coverage more affordable.

The Commission recommended that a high risk health insurance pool be established as a separate entity within the State of New Jersey. Premiums for this high risk pool would be no higher than 150% of the amount charged in the standard insurance market. A subsidy would be established in order to meet the costs of claims in excess of 150% premiums.

Creation of this high risk pool would alter BCBSNJ's role as the insurer of last resort, but the Commission believed, and BCBSNJ concurs, that BCBSNJ should be allowed to prospectively place a certain number of high risk individuals in such a pool.

Since the enactment of legislation creating the existing Hospital Rate Setting Commission, BCBSNJ has seen the evaporation of any competitive price advantage it once enjoyed over its commercial competitors. Prior to that rate setting law taking effect, Blue Cross enjoyed what amounted to a 25% discount, over commercial carriers. This discount was achieved by negotiating aggressively with providers. Due to this large discount BCBSNJ was able to hold down the cost of coverage for its individual non-group subscribers, since the discount was utilized to subsidize premium costs for individuals.

The Blue Cross and Blue Shield Study Commission recognized that under the current hospital rate setting system, BCBSNJ could not longer maintain its position as the insurer of last resort. It is for this reason that it recommended the creation of a risk pool. It should be noted that several states have already enacted legislation establishing such risk pools.

As you are no doubt aware, the Appellate Division of the Superior Court of New Jersey recently determined that BCBSNJ could not utilize demographic rating in setting its premium rates for non-group subscribers. The Court ordered the Department of Insurance to expeditiously review the rate increase filed by BCBSNJ on November 14, 1989. In response to this decision, BCBSNJ filed for a revised rate increase with the Department of Insurance. That increase is currently under review.

BCBSNJ is concerned about the impact of the Court's decision on our ability to continue to provide health insurance coverage to direct pay customers. Under the terms of the Court

decision, BCBSNJ must revert to community rating for its direct pay customers. Under community rating, one rate is charged to all customers who retain the same coverage. Demographic rating, which is used by commercial insurers, recognizes that certain factors -- age, sex, and location of residence -- determine how often individuals utilize benefits. BCBSNJ is very concerned that better risk individuals enrolled in our non-group book of business will be targeted by commercial insurers, who through demographic rating will be able to offer them the coverage at rates substantially lower than those provided through the community rated individuals in the same pool.

As better risk individuals leave the community rated pool, adverse selection results. Under adverse selection, premium increases cause the lowest utilizers of benefits to leave the insurers pool; either to purchase other insurance, or to go without insurance. When these individuals leave, premiums collected decrease disproportionately to the amount of claims generated by those remaining. As a consequence, larger and more frequent rate increases become necessary. As new higher rates are needed, the next lowest group of utilizers opts out of the community pool, and the cycle begins all over again. The report issued by the Blue Cross and Blue Shield Study Commission recommended that BCBSNJ be allowed to employ demographic rating for its non-group subscribers. Based on the Court's decision, this is no longer possible. The actual impact of this decision is something which concerns BCBSNJ greatly, since it will probably make it even more difficult for us to provide non-group insurance at all.

This testimony, so far, has focused primarily on the problem of providing affordable health insurance to individuals who do not receive health insurance as a condition of their employment. Studies have shown that most of the approximately 800,000 New Jerseyans are, in fact, employed or are the

dependents of an employed person. BCBSNJ recognizes that the cost of health insurance is a significant burden on many employers, especially those who operate small businesses. It is certain that if group insurance was more affordable, then at least a portion of the State's uninsured population would have coverage provided to them by their employers.

BCBSNJ believes that there are programs which can be undertaken which would reduce the cost of health insurance to employers, especially small employers. If this can be accomplished, more employers are apt to voluntarily provide insurance to their employees. As the number of uninsured declines, the pressures on the State's hospital financing system should also decline.

Some of the programs which this Commission might wish to explore further could well require the use of scarce State revenues. BCBSNJ is well aware of the fiscal situation which confronts our State in 1990. Money may not be available at the present time to institute these programs, but that does not mean that the possibility of instituting these changes is not worth exploring further; when these fiscally difficult times pass, it would be prudent to have fully investigated various proposals designed to contain health care costs. Some of those might be as follows:

1. Expanded governmental funding for uncompensated care.Ultimately general revenues are a fairer more equitable way to fund this program. While State monies may never be able to fund this program fully, consideration should certainly be given to expanding the Medicaid program. Expansion of Medicaid would bring in additional Federal dollars and increase the number of people who have access to health care.

2. Creation of a risk pool for high risk individuals -- which I spoke about briefly a moment ago. For the

reasons outlined, it is becoming increasingly difficult for BCBSNJ to perform its task as the insurer of last resort. If the risk pool cannot be established, then consideration must be given to instituting some form of broad based subsidy for those individuals who must purchase their own health insurance.

3. Programs to encourage small businesses to provide their employees with health insurance benefits. There are several states who have already undertaken programs, one of which is Oregon, which recently enacted legislation which provides tax credits to small businesses which provide health insurance coverage to their employees. Increasingly, the number of individuals who receive insurance through the work place will ultimately have a positive impact on the premiums of all employers.

The above referenced suggestions would require that legislation be enacted before these programs could take effect. Significant public policy questions would need to be addressed to ensure that the most appropriate and equitable programs were put into place. Before instituting these suggestions significant research needs to be done.

As an immediate step, BCBSNJ would make one suggestion to this Commission and the entire Legislature of New Jersey. While all parties strive to achieve a program designed to contain health care costs, no action should be taken on any legislation which would mandate benefits for health insurance premiums. When the Legislature intervenes and requires health insurance to provide coverage for specific providers or services, it increases the cost of health care. Recently, the States of Washington and Virginia have enacted legislation waiving the imposition of mandated health insurance benefits on

small group health insurance contracts. BCBSNJ believes a proposal of this type would have merit in New Jersey; today, however, we only recommend that the Legislature defer from enacting new mandated benefit legislation.

It is certain that health care will be one of the dominant public policy questions here in New Jersey and throughout the United States in the 1990s. The controversy generated from the recently released Pepper Commission report shows that the issue will continue to be debated in Washington. Governor Florio has taken the lead by stating that one of the major public policy goals of his administration will be to address the health care system in our State. The establishment of this Commission clearly shows that the Assembly intends to be an active partner in finding solutions to the problems at hand.

Blue Cross and Blue Shield of New Jersey is ready to work with our elected leaders in state government and other interested parties to develop programs designed to make health insurance more accessible and affordable for New Jerseyans. BCBSNJ sells health insurance to employers, labor unions, and individuals in this State. Our past success has been due to our ability to provide New Jerseyans with quality health insurance coverage. Working in conjunction with this Commission and similarly concerned groups BCBSNJ looks forward to the challenges and opportunities that lie ahead.

ASSEMBLYMAN McGREEVEY: Thank you very much. Would you mind answering a few questions?

MR. SIAVAGE: Not at all.

ASSEMBLYMAN McGREEVEY: I guess in reverse order of testimony-- You've heard obviously Commissioner Bramucci's testimony as to the increasing ranks of the uninsured among the employed. We also noted in your testimony the burgeoning impact of the Uncompensated Health Care Trust Fund on the State and also Blue Cross. In that light, it's interesting in the

fact that you take the position in that New Jersey ought not mandate health care benefits because it would have an adverse impact on the State's health care system. Could you flush that out?

MR. SIAVAGE: Yeah, what we're really talking about there is specific mandation of specific benefits, as has been done in the past with say, alcoholism, substance abuse, etc. -- that general area of mandating specific benefits. The idea as Commissioner Bramucci talked about with respect to draconian mandation of insurance coverage for all employers, I think is probably also, in our opinion, the correct route to go. That is not an automatic knee-jerk mandation of benefits, but what we're really speaking about in that section is specific mandated benefits.

ASSEMBLYMAN McGREEVEY: When you're talking about $.30 of every $1 of your hospital premium going to the care of someone else other than your subscriber, how do you encourage, how do you require, how do you expand the scope of those that are insured?

MR. SIAVAGE: You mean to lower that amount.

ASSEMBLYMAN McGREEVEY: Yeah.

MR. SIAVAGE: Well, one of the ones that we've talked about is the third; that is, giving some tax credit to small businesses so that they begin to have an incentive to insure more people who are working.

ASSEMBLYMAN McGREEVEY: That would be a vast and incremental incentive.

MR. SIAVAGE: Assuming that there is one now?

ASSEMBLYMAN McGREEVEY: Assuming that the tax incentive would have to be such that it would provide significant enough incentive that it would offset the cost of the benefit.

MR. SIAVAGE: Yes, there is a whole panoply of approaches that have been considered and passed by dozens of

states including Wisconsin, Oregon, Maine, New York, Washington, Virginia, Michigan, Illinois. The choice of the Oregon one is one that we made as probably ground zero. They go all the way up to almost mandation.

ASSEMBLYMAN McGREEVEY: But clearly it's an interest of Blue Cross to want as many people insured as possible.

MR. SIAVAGE: Absolutely.

ASSEMBLYMAN McGREEVEY: I guess I'm just groping with that to do that sometimes takes a willingness to step to the plate.

MR. SIAVAGE: That's why we would work with the Commission members to see how far they'd wish to go.

ASSEMBLYMAN McGREEVEY: On the high risk health insurance pool as a separate entity, in light of the State's dismal record with the JUA, how would you be able to contain the membership of the high risk pool and its relationship to the insurance corporations and their general subscribers?

MR. SIAVAGE: To borrow from Commissioner Bramucci's testimony very carefully: There are good lessons again from other states in that area. At last count, I think there were 18 high risk pools. Pretty much what it comes down to as a top in as the rationing of benefits. You cut off the benefit level, so you can't have JUA types of sins, and you provide some benefit, considerable benefit to these people.

ASSEMBLYMAN McGREEVEY: Could you flush out, if you could, the scope of benefits, say for example, somebody in the high risk pool?

MR. SIAVAGE: I really couldn't for you now, but we could get that to you.

ASSEMBLYMAN McGREEVEY: Okay.

MR. SIAVAGE: The point is that approximately -- every last individual pooled -- 20% of the people make up about 80% of the claims in the high risk pools in an attempt to get at that issue. It's not, nevertheless, a panacea because the

effect of it on health care insurance premiums probably wouldn't be felt for several years.

ASSEMBLYMAN McGREEVEY: And who would pay for the high risk insurance in a high risk insurance pool?

MR. SIAVAGE: Where the Study Commission looked at several alternatives on that $64 question from general revenues to specific taxes, and came down to an increased differential.

ASSEMBLYMAN McGREEVEY: So, what incentive would there be for the insurance companies not to put someone in the high risk pool?

MR. SIAVAGE: First of all, I believe that the only insurance company who would really be effectively putting people in this would be hospital service corporations -- Blue Cross and Blue Shield -- because the market just isn't there for private insurers and the recommendation of the Study Commission also was that BCBSNJB, at least for the early period, be the administrator of that pool.

ASSEMBLYMAN FELICE: Mr. Chairman, you mentioned on the high risk pool and rationing, which Oregon is doing to organ transplants and other things. They feel that it's not going to be worth the investment to save those lives, where they can utilize that money for other things. One of the things that certainly hasn't been brought up as a high risk, is going to be brought up very shortly I'm sure: How about the AIDS problem that we have in New Jersey and the United States? What is the role of Blue Cross and Blue Shield in that situation? And for those people that are part of the health care program and now all of a sudden come into one of the highest risk pools? What is the position of Blue Cross/Blue Shield as far as that high risk program?

MR. SIAVAGE: We do have AIDS patients in our covered population. For open enrollment we apply a one-year preexisting condition and then allow the people to come in to what we call co-op coverage after that, and there are

individuals with that disease in our covered pool. It has not been -- I've got to be honest -- in New Jersey, the problem that it's been in some other states at this point in time. We're not sure why yet, but our claims levels for AIDS patients have not been astronomical.

ASSEMBLYMAN FELICE: One last question, in that one-year coverage what percentage do they then pay after the one year?

MR. SIAVAGE: They pay a full percentage of rate, but they pay it in a community rated environment. They pay the same as everybody else does in that pool. That's the point, the high utilizers pay the same as everyone else, which is the problem that demographic rating began to address.

ASSEMBLYMAN McGREEVEY: I appreciate the concerns that you raised on top of page four of your testimony. In light of the DRG system, what, if any, method would you suggest to develop some type of advantage for BCBSNJ in terms of continuing the business that they're in?

MR. SIAVAGE: I don't-- If I might, I don't think the advantage is really the bull's eye of the target. I think that-- First of all, I think that there's no free lunch, and right now, all the looks that everyone will be taking will show that there's simply not enough money in this system to keep rates down.

The answer is that more money has to come from someplace to go into the system. If that rate money comes from higher premiums, we're going to have the rate spirals that I talked about which will later move over into corporate and small group. Employers just won't have the ability to pay for it and they're going to be looking to the Legislature again for the answer to that question.

The real question is where the money comes from, and we are again ready to work with you as to where that is. If it's general revenues, that's one thing; if it's an increased

differential, it's another. And the mechanism is now there with the Hospital Rate Setting Commission. We currently get a 2.54% differential to subsidize the individual pool. It was at one time almost 30% in the 1979 legislation, the last time issues like this were looked at, which was pretty significant at the time. The statute changed that differential at 10%, it was later changed by a floor amendment to 5%, and has eroded since. That's one area of possibility to infuse more money into the system, that would need to be looked at; one that we would be in favor of if it was chosen by the Commission.

ASSEMBLYMAN McGREEVEY: You talked a little bit about the programs that you suggested in terms of small employers. What can be done to increase the affordability and the attractiveness of small employers for the insurance industry?

MR. SIAVAGE: I think you can choose how big a carrot and how big a stick you want to use in respect to small employers. The Oregon plan is totally incentive, tax credits. There is movement in Oregon in a few years to begin to tax, I believe, those same small employers. It's not something that we're recommending right now, but that's one of the other ways to go at--

ASSEMBLYMAN McGREEVEY: But in terms of-- Excuse me, I'm sorry -- I meant in terms of, frequently a small employer finds the insurance industry unwilling or uninterested in-- Senator Kennedy has in his national health care program has development of these pools of potential customers. In the State of New Jersey, it's very difficult for the small businessman to get insurance because frankly the risk isn't spread over a large enough population. What do we do as a State to encourage, or coerce, or provide a carrier for the insurance industry to cover the small employer? Perhaps it's the other side of the coin, the small employer, as Commissioner Bramucci noted, isn't getting the insurance, perhaps, because

the insurance provider doesn't find them to be an attractive risk.

MR. SIAVAGE: Difficult question. We insure -- I just checked the number -- 423,000 individuals who are in, what we call, our small group population now. That would be a group size of 49 and below, which we recently came to the Legislature to allow us to experience rate about a year-and-a-half ago. We've developed, since then, several products for the small employer and really the marketplace now would suggest that many of them are purchasing down, if you will, to provide a level of health insurance at a cost that is fairly even, and the only way to do that is to cut back on some of the benefits.

The insurance marketplace only responds to the need of its customers. It won't lose money and neither can we now. So again, there's no free lunch, and I'm not sure what you can do to provide an incentive other than perhaps the expansion of programs that make the population smaller, or better risks.

ASSEMBLYMAN IMPREVEDUTO: So far we're talking about trying to have rates so that people can afford them, and we're saying things like, one of the ways you can do that is the State and general revenue can help pay for this, and finding places where money can be brought in to help pay for the cost of insurance. But I haven't heard anybody talk about the other end of it which was, you can find money, but another way to help control the cost is to bring down the cost on the other end; doctors, hospitals.

Suggestions on, yeah maybe we can find revenue somewhere else to help pay for it, but let's look at the other end where we can control the cost, or lower the cost of current health care providers. Any suggestions there?

MR. SIAVAGE: I wish I had some. I'd be pursuing them now if I did. Let's start with the insurance companies themselves, or at least BCBSNJ, for which I speak. We take seven cents out of every dollar that we get in premiums before

we give it back in claims. We constantly look at our operation to see whether there are any efficiencies that can result from tightening the belt a little bit further. We ranked seventh or eighth in the nation on the cost of claims administration, and the states that are above us are not what you would call highly industrialized states. They're mainly rural states. Out of the industrial states I think we give the best bang for any buck any BCBSNJ plan, so there isn't a lot where we're concerned.

With respect to the hospitals, I think that a look at national statistics would show that New Jersey's group of hospitals provides care at a reasonably low level, again compared to the rest of the country. There are a lot of attacks on the DRG system recently, and one might argue as to what the reasons for our low hospital costs are, but we do not have, compared to the rest of the nation, exorbitantly high hospital costs. Doctors are an issue which is-- We have Blue Cross and Blue Shield talking to doctors all the time.

We've talked currently about managed care, and have gotten extensive and excellent cooperation out of the medical community on bringing down the cost of certain procedures, like cesarean sections, certain cardiological procedures that we're talking about now and managing care which will be the watchword of the 90s.

We need to do a better job. Insurers need to do a better job at managing that care, and that's one of our biggest challenges for the 1990s.

ASSEMBLYMAN IMPREVEDUTO: So, you really have no suggestions then, besides paying for a physical for preventive medicine type things?

MR. SIAVAGE: There are no magic answers right now.

ASSEMBLYMAN IMPREVEDUTO: But I think that we just seem to be focusing in one direction, and that's how to raise more money to pay for this, instead of saying well, maybe we

can raise a few bucks more, but we've got to lower the cost, at some point, on the other end. We're looking at a half a billion dollar budget deficit here, the Governor recommending raising some taxes, but it's also cutting some costs. We've got to be able to do both, and what I'm hearing is maybe that our hospitals are doing the best that they can. Their cost is down as low as it possibly could be, and doctors, well, their costs are kind of low. Well, if their costs are low, and the hospital costs are low, why are the rates going up?

MR. SIAVAGE: I think one of the reasons that this is difficult is because of Americans -- the United States of America being the biggest consumptive society as far as health care costs, of anybody in the world. There were some statistics in The New York Times a couple of weeks ago, that if you smooth per capita income worldwide and still look at the amount spent on health care, the United States spends three times as much per person on health care as any country in the world. Now, how do you get at that?

Some reasonable attempts have been made through HMOs, PPOs, Allied Signal's experiment, different kinds of experiments in companies to really get at the mentality of the user, which is the subscriber. That is a cultural change that's going to take a good deal of time, one that we're working on, and I'm sorry that I don't have any specific answers for you, but we do have some initiatives that we've undertaken at Blue Cross and Blue Shield, and I'd be happy to come at those with the Committee.

ASSEMBLYMAN McGREEVEY: We'll be having a series of hearings. I think the focus today is just on who is covered and who isn't covered, and the impact on the fund. Could you speak to that issue in terms of not only Blue Cross and Blue Shield, but in terms of the general insurance pool for those who are uninsured in the State? Could you speak to those? Where do they fall?

MR. SIAVAGE: I agree with Commissioner Bramucci's percentage, which is the one that's usually relied on. Eighty nine per cent of the people are covered which leaves 11% uncovered was a number of about 834,000 people. We also subscribe to the fact that most of those people are employed. I'm not sure whether 40% is the right number or not, but most of those people are employed.

We insure 3.3 million and I guess it's safe to say that the balance would be either unemployed -- well no, they'd be in the 834 too, I guess the rest would be commercially insured.

ASSEMBLYMAN McGREEVEY: I've seen -- I guess there was a series of articles in the Asbury Park Press -- that they published a breakdown of New Jersey's 843,000 uninsured. Is that pool expanding?

MR. SIAVAGE: It will be soon, if our rates continue to go up, and we've undertaken initiatives to try to prevent that, but if they do, we'll be looking at another big rate increase in the fall. If they do, people will be going uninsured out of our individual pool, in addition to the employers and the small groups who decide not to cover employees anymore.

ASSEMBLYMAN McGREEVEY: In light of that, do you still feel that it's not within the health interests and the financial interests of Blue Cross to require a mandated health care policy?

MR. SIAVAGE: No, not at this point in time. I wouldn't come out and say that. At this point in time in our look, I wouldn't take that position.

ASSEMBLYMAN McGREEVEY: Well then, how do we-- It's a very simple equation, if less are out of the system, the costs go up. How do you--?

MR. SIAVAGE: Because-- I understand what you're saying. It's an extremely delicate balance that has been

created, an extremely intricate system of health care financing in this State. One of the reasons that we're upset with losing demographic rating is that you can't tinker with one end of this Rube Goldberg system and expect that something isn't going to fall out the other side. So a strict mandation or a strict knee-jerk reaction at one point in the system is going to create other problems in the system. It may not evidence themselves for a couple of years, but the reason that we applaud the look that this Commission is taking and Governor Florio will, is that all the interests need to be looked at; all the pipelines in the chain, if you will.

ASSEMBLYMAN FELICE: Mr. Chairman, if I may add, in one of the articles it states that the 35% of all the nation's hospitals have 35% empty beds and the patients are paying for empty beds when they go in there. What programs do you foresee? How can we utilize those beds for other health care programs, or joint programs to utilize those empty beds and space to help reduce health?

MR. SIAVAGE: I'm not sure that the answer is to utilize them. I don't have any specific programs on how you fund beds which are empty, given the building and land costs etc., that goes into hospital costs to finance those beds in the first place and the effect that they have on hospital financing. I really don't know the answer to that, Assemblyman.

ASSEMBLYMAN McGREEVEY: Jack?

MR. FAY: Michael, if the Governor and the Legislature did accept all the major recommendations from the ADA Commission and if there are some other states that are moving in the right direction, Oregon and say, others, if the accept the "Son of JUA" and other recommendations like that, are we still like concluding that "X" number of people are expendable? I mean don't we have to come into this whole view and say yes, there are people who literally can't afford this now and most certainly with the ever increasing rates? That

percentage of-- Yes, we have to conclude there are some people who are going to be expendable. As much as those who are not working which are frightening in themselves in their numbers, but the very idea of those who are retired, the 25 year old or the 35 year old who is not making much more than minimum wage and trying to raise a family, there is a bottom line that says yes, "X" number of people cannot afford this. "X" number of people are not going to be able to stay in the plan with one more, two or three more, like legitimate business increases.

MR. SIAVAGE: An almost philosophical question that we struggle with day by day at Blue Cross and Blue Shield, Jack, sometimes in the public media on the question of what kind of care we should compensate or reimburse and what people are really entitled to, and what they're not entitled to. It's an unfortunate fact, I think in a capitalistic society, that if you have the means, you can get better health care, better any kind of care that you wish. The question with respect to health care, particularly when you get down to a life or death situation, is where is that line going to be drawn?

For instance, organ transplants is a good example, I think. We found, several years ago, that the cost of an organ transplant simply couldn't be borne by a pool of insured people, and what happened was the Blue Cross and Blue Shield Association got together with a reinsurance vehicle, so that now we are able to pay for organ transplants. It was a well-hailed reaction to a very difficult problem. But I think that issue you state, underlies every health care financing problem, and now the whole system because of the kinds of increases we're looking at.

MR. FAY: Like we could change our name to like, Savings and Loans, some kind of a catchphrase like that, where they--

ASSEMBLYMAN FELICE: They've got enough troubles.

MR. FAY: --find $300 billion.

ASSEMBLYMAN IMPREVEDUTO: Blue Cross Savings and Loans.

ASSEMBLYMAN FELICE: BCS&L.

ASSEMBLYMAN McGREEVEY: Assemblyman Cohen.

ASSEMBLYMAN COHEN: Savings of Lives. There's one area you may face in terms of mandated, unless certain more humane and equitable steps are taken, and that deals with bone marrow transplants. I don't think the corporate board room should be making decisions as to whether someone's going to live or die; one who puts into the system for 15 or 20 years and then is faced with cancer, and must then fight.

I had a friend who had to undergo this procedure; a very painful, very lonely situation and she was tested and prepped, everything, so she could go to Boston. Then she was told 48 hours before that they would not pay for it, and that she would have to come up with $60,000. It's an outrage. One doesn't have to litigate while they need something which is going to determine whether they have a chance at life. That's one area that I'm going to deal with in terms of legislation concerning mandating that payment, particularly where there has been either a history of cancer, but the employer accepts the person as an employee, and they're productive. One shouldn't have to go through litigation while they're trying to fight for survival. I think that's one area of mandated benefit that I think you may have to address shortly.

You mentioned a question concerning organ transplants and there was a way in terms of pooling dollars and pooling resources or pooling within the insurance community, so that that could be provided to for someone who is a candidate. I would hope that someone would move toward that in the area of bone marrow transplants which is becoming more and more common and it is not experimental. The rates are not as high in terms of success as open heart surgery perhaps, but things change, technology changes, and someone shouldn't have to hinge whether they're going to survive or not based upon an administrative

decision. I think we are probably more advanced as a society than to be faced with that. That is something that I am going to address shortly with Assemblyman Adubato.

MR. SIAVAGE: Can I just respond to that for one second, Assemblyman?

ASSEMBLYMAN COHEN: Sure.

MR. SIAVAGE: As our Medical Director said on the stand, I am not an ogre and we don't consider ourselves to be a collection of ogres at Blue Cross and Blue Shield and--

ASSEMBLYMAN COHEN: Oh no, we don't kill the messenger.

MR. SIAVAGE: --the decision was not made at an administrative level. It was made at a very high level. As a matter of fact, I was in the room when it was made. The question really comes down to, is there anything that you won't reimburse as a health insurance coverer? Is there anything that you won't reimburse? Will you pay for every bottle of snake oil, whatever it is?

Once you get to the point that there is something that you won't pay for, you've got to decide what it is. You've got to decide what it is, and that's not an easy decision. That decision revolves around whether whatever it is has a curative effect. What you do at that point is you try to find what anyone has written, what anyone has said, what successes or failures anyone has had, before you say, "The rest of you people, the other 3.3 million people are now going to pay for this," because that's effectively what happened.

The case that was in the paper, everybody else is going to pay for those dollars that go for that treatment. That sounds very cold, but I come back to the philosophical premise, that once you decide that you're not going to pay for everything, you've got to decide what it is, and it's got to be curative. In that case, the proofs were in our opinion that it wasn't. A judge decided otherwise, but we decided to pay for it while that litigation was going on. We're looking at ABMT

right now to see what we're going to do, and we're well aware of the bill.

ASSEMBLYMAN COHEN: In advance of this, I spoke to some physicians who indicated New Jersey's malpractice insurance rates 43rd in the nation in terms of its costs. So that seems to be doing pretty well. As pointed out before by the members of the Committee, if hospital costs are relatively reasonable and malpractice insurance is 43rd in the nation, not number two, or three, or seven, like we are in terms of car insurance, there seems to be some problem endemic in the system.

MR. SIAVAGE: Well, it depends--

ASSEMBLYMAN COHEN: What percentage of administrative costs, in premiums?

MR. SIAVAGE: Seven.

ASSEMBLYMAN COHEN: Seven percent. Total?

MR. SIAVAGE: Total.

ASSEMBLYMAN COHEN: All revenues taken in, 7% goes to administrative costs, and the rest of it goes to pay out the claims?

MR. SIAVAGE: Forget all revenues, if you take premiums, 7% of premium dollars is taken out for administrative costs. The rest is given back in claims payments. I think-- If I could respond, Assemblyman Cohen. One of the other things is that we've looked at premiums being paid by other states, that is individual coverage in comparable industrialized northeastern states: Delaware, New York, Massachusetts, and prior to our last rate increase, we came out the lowest out of those states. There were some cases for instance, Delaware, I think, was $8400 for family coverage from Blue Cross and Blue Shield for similar benefits. You have to equate the benefits first because the packages are different. Once you do that, New Jersey comes off quite well with respect to premiums, so the question is "compared to what?" I guess, at all times.

ASSEMBLYMAN COHEN: I have a question in terms of competition in the industry. For instance, at the county -- in Union County I'm a Freeholder also -- we worked out, in terms of negotiating with various carriers for health care coverage for the employees -- we ultimately took the Blue Cross package, but we were able to negotiate a second year with a 30% cap on any increase, which still brought in less money than some of the other-- I'm just wondering whether the industry is looking into more competition, instead of a year to year, where all of a sudden as people have called my office, they wake up and they've got a notice that they're health care has increased by 35%, and you've got to pay the bill within 30 days. There's no type of planning that can go into monitoring your own health care costs, and I'm just wondering whether instead of a year to year, whether anyone is looking into more packages for individuals and groups through your plan -- five year plan which takes into consideration claims history experience with that individual of the group?

MR. SIAVAGE: The large group market now is almost custom designed for every account that you approach. There really isn't lay the 1420 on the table, walk away, and wait for the phone call anymore. Almost every large group over 1000 is custom designed with respect to the insurers, and whoever gives the best rate, the best deal on guarantees, the best managed care, etc., etc.-- It's a very difficult market now at that level.

ASSEMBLYMAN McGREEVEY: Thank you very much, Michael. During the course-- Just to reiterate, we're going to have five hearings, and that the purpose of today's hearing is just to ascertain who has health insurance, and who doesn't, and the degree and the scope adequacy or inadequacy of that health insurance. So we'll be looking forward to talking to you in the future. Thank you.

MR. SIAVAGE: We will be happy to cooperate in whatever way we can, Mr. Chairman.

ASSEMBLYMAN McGREEVEY: Thank you. The next one on our list, we have Mr. James Cunningham, President of The New Jersey Association of Health Care Facilities.

J A M E S E. C U N N I N G H A M: Thank you very much, Mr. Chairman. For any of the members of the Commission who aren't familiar with me or my organization, I represent the New Jersey Association of Health Care Facilities which represents nursing homes, intermediate care facilities, residential health care facilities, and medical day-care facilities.

It's really going to be a change of pace from what you've heard this morning, and if I had realized that you were going to deal heavily in this issue, I probably would not have appeared today, but would have appeared later when you deal more with long-term care and community care. However, in seeing the schedule of your hearings, we would urge, naturally, that you hopefully expedite your long-term care/community care portion of your work.

We appreciate the opportunity to appear before you this morning and look forward to working with this Commission to examine health care issues which affect New Jersey citizens.

Please let me commend you on the timing of this public hearing. Last week an in-depth <u>New York Times</u> series, reflecting the heightened interest in the subject among a variety of important media outlets, reported on the exponential growth of the elderly ill, their health care options, and the problems they face in--

ASSEMBLYMAN McGREEVEY: Jim, excuse me, in the interest of time could you focus, if you have something specifically, on health care and perhaps insurance for long-term health care insurance, home health care insurance.

MR. CUNNINGHAM: That is the initial issue.

ASSEMBLYMAN McGREEVEY: Okay.

MR. CUNNINGHAM: And then I'll get into paraphrasing because really we're going to deal with the areas: that health care issue, the access problem that's growing for the elderly in the Medicaid insurance--

ASSEMBLYMAN McGREEVEY: Today we just want to focus, very narrowly on the whole question of the adequacy of health care coverage, and that obviously does include home health care and catastrophic health care coverage.

MR. CUNNINGHAM: Home health care is the one area and the hospital area, are the two areas that I won't deal with. We deal with all but the acute care setting--

ASSEMBLYMAN McGREEVEY: Okay.

MR. CUNNINGHAM: --and the home health area. In the insurance area for the elderly, I'm sure that you're very familiar with the cost of long-term care is over $30,000 a year, and it does drain the savings of a patient and his or her immediate family.

Private insurers have developed policies designed to cover the cost of this care and relieve families from the humiliating experience of "spending down" to poverty. Unfortunately, many policies sold today likely will be of little benefit when it's time to draw from them. Typically, these policies neglect to project accurately the future costs of care.

We urge you to do two things: 1) create a process to review those policies which cover long-term care. It's critical that consumers be assured that the policy they purchase today will truly offset the costs of long-term care many years in the future.

As a guideline, you might want to borrow from New Jersey's Long-Term Care Insurance Program, that's a pilot project that's going on now, funded by Robert Wood Johnson. There are nine of them going on in the country. This program is slated to begin this year, and is designed to devise a plan

to protect families from "spending down" in order to pay for skilled and custodial care at home, or in an adult care center, or nursing home. It also includes an annual inflation factor which would ensure that a policy covers the future costs of care. Before this program can begin, the Legislature -- you, the Legislature -- must approve a measure to indemnify that project. That's the second area that you could get involved. This pilot program is going to be marketed through NJEA -- New Jersey Education Association.

ASSEMBLYMAN McGREEVEY: Could you tell us how it works please?

MR. CUNNINGHAM: It will be sold originally to all of the teachers, their spouses, their families. Unbeknownst to me until I was involved in this process, NJEA also represents the bus drivers, the custodians, and the like.

ASSEMBLYMAN McGREEVEY: But how does the health insurance program work?

MR. CUNNINGHAM: There is a premium available to that group that will provide long-term care insurance coverage to that group for a period of time. I think the time -- I don't have the papers with me -- is two years. It will be normally affordable by all of the teacher groups, but for those that it won't be, there's a graduated scale down towards the poverty level.

ASSEMBLYMAN McGREEVEY: Who's underwriting this insurance program?

MR. CUNNINGHAM: It would be underwritten by an insurance carrier who will be bidding on the project. They have several biddings on it. The indemnification here is because of the subsidization of that premium for the low cost people, low salary people in that group. The reasons being done in this group is that's a very controllable group as far as data. Is it working? Is it a proper policy? So I think that you'll find that of great interest. I know there's

movement by the Department of Human Services that is controlling this pilot under Robert Wood Johnson, through the Governor's Office, to get movement on the legislation to indemnify this project so it can move forth.

As you know too, Congress is also examining this issue. I hold a little more hope for it than Commissioner Bramucci does and think that you're going to see such a policy in the next three to five years, that will make the proper coverage coming out of the Federal government.

The other issue I'd like to deal with quickly and briefly-- All of you received a copy of a legal petition from us that was served upon the Department of Human Services a few months ago, indicating what we see as their violation of Federal law and the risk of 330 million Federal dollars coming into this State in long-term care for the Medicaid program. It's fairly apparent to us they're in violation of the Federal law. The payment rates and the losses that you see in the document that I have given you, will tighten access for the poor, frail elderly, and I don't mean in the distant future; I mean in the very immediate future.

Speaker Doria has sponsored a bill to correct this situation. Senator McManimon, in the Senate, has a like bill. We'd like to ask today that the members of this Committee go on as co-sponsors with Speaker Doria for that legislation. We intend as an organization to pursue this problem to a resolution, wherever it may take us. We're hoping, we tried administratively-- The Department's asked until next September to study their own data. We indicated to them that by Federal law, they have to know where they are, today, yesterday, and tomorrow, and certifying the Federal government they're in compliance, and we don't see why they need until September to find out that we're in trouble.

The last item that I'd like to bring to your attention deals with the Nursing Shortage Study Commission that was named

under an emergency order by Governor Kean, which completed a report almost a year-and-a-half ago now that had certain recommendations to solving labor shortages in the hospitals and the nursing homes; nursing shortages -- predominantly nursing personnel. We haven't seen any movement on that document. This also is causing an access problem because you get facilities that either open, or have been in business for quite awhile that have to close beds or close units because they do not have the nursing personnel to staff those units.

That Commission came out with certain recommendations, some of them will take legislative intervention. Most of them are not of the tremendously expensive nature that the Medicaid item is. We're hopeful that this Commission will look in the area of either State tax credits or low interest loans for nursing students that are forgiven after graduation, if that person stays in that profession, in the health care field in New Jersey, for say five years.

I think that is doable. We're starting to see some of that come into Congress. We're looking for control and regulation of the temporary agencies that the Commissioner talked about this morning that are seriously driving the costs crazy. There are several other issues in our testimony that can be followed legislatively with the implementation of appropriate legislation.

ASSEMBLYMAN McGREEVEY: Thanks Jim. I think some of your comments are going to be very helpful when we get to the long-term component. If it would be possible -- today we are just focusing on the insurance element -- if you could forward us any information you might have on the Robert Wood Johnson Foundation pilot project for long-term care insurance, that would be helpful. Is there any specific question on the insurance question on long-term health care?

MR. CUNNINGHAM: There is a bill in Congress--

ASSEMBLYMAN McGREEVEY: Yes.

MR. CUNNINGHAM: --to continue that pilot also and allow it to go forth that you might--

ASSEMBLYMAN McGREEVEY: Senator Bradley also has a long-term health plan. Thank you very much, Mr. Cunningham.

MR. CUNNINGHAM: Thank you.

ASSEMBLYMAN McGREEVEY: The next on the list-- It's our distinguished privilege to have Al Evanoff from the New Jersey Health Care Coalition.

A L E V A N O F F: Jim McGreevey, members of the Commission, and staff, Jack Fay. The New Jersey Health Care Coalition consists of unions, senior organizations, children and disabled organizations, and persons interested in accessible, affordable, high quality health care. On behalf of the Coalition, I want to thank you for the opportunity to appear before you today and present our views on some important health matters for New Jersey.

When we discuss the question of accessibility to health coverage, we have to bear some facts in mind, and I don't mean the statistic of 37 million Americans being uninsured.

Last week the Census Bureau issued a report that 13% of all Americans are without health insurance. That is 31.5 million people. The startling part of the report is that in the age bracket of 16 to 24 years of age, there are 21.9% lacking coverage and 16.2% of those 25 to 34 years of age are uninsured. Further, the report noted that 26.5% of the Hispanic Americans lacked coverage in 1989. The percentage of Afro-Americans lacking coverage was 20.2%. This compares with 11.7% of white Americans who were uninsured.

Just prior to this Census report, the Pepper Commission or U.S. Bipartisan Commission on Comprehensive Health Care estimated that in addition to the Americans who lacked coverage, there were as many as 20 million who had inadequate health coverage.

Couple this with two other factors, and we have a major disaster in the making. The first is the fact that the New Jersey Uncompensated Trust Fund is reaching the $600 million mark. The other is the fact that A. Foster Higgins & Co. of Princeton, an establishment which monitors employer health care costs, reported that employer costs rose an average 20.4% in 1989, up from $2160 per employee to $2600. By the way, we fall somewhere in the $2800 bracket in New Jersey. We're right between Philadelphia and New York, and therefore it's about that amount. The New Jersey Health Department reports show -- and this has been talked about -- we have 843,000 people who are uninsured. Of this, 59% are working, which means that 497,000 New Jersey residents are employed and have no health insurance. If these people need hospital care in our State, they would most likely register for charity coverage and have their bills paid out of the Uncompensated Care Fund. Just as in the nation, we have 24.8% or 209,000 of our 18 to 24 year olds that are not covered. We have 27% or 227,000 children and those under 18 years old who are not covered. These are Health Department reports of 1987.

With so many people throughout the world looking to us to demonstrate that democracy works, we have the responsibility to go beyond having commissions and issuing reports. We need some laws that will show we care about our children and really know how to live together by finally beginning to put an end to racism and other bigotry. And that showed up in the percentages of Hispanics and Afro-Americans who are not covered.

When we speak of access to health care, too often we quote the statistic of 37 million Americans lacking health insurance. The problem goes far beyond the question of what uninsured persons do when they become sick. In New Jersey, we have our Uncompensated Trust Fund which covers the uninsured and pays their hospital bills. That fund is now about $600 million annually, and still going up. The truth is that the

uninsured person by the nature of our system is forced to delay care until he or she is faced with an emergency, and ends up in the emergency room of the closest hospital and possibly is admitted. The cost of this procedure is the most costly way to administer care and is a factor in increasing health care costs.

Besides the cost, the effect on the patient is also destructive. A visit to a doctor earlier may prevent, through medication or other treatment, the need for emergency room or hospital admission. Add to this the fact that under uncompensated care, the third party payer have to share the cost of the uninsured persons care, resulting in increased cost and eventually increased premiums to the consumer. We've talked about that here. This has a snowball effect. Employers faced with increased premiums cut or cancel their health benefits package, adding additional persons to the list of uninsured.

Our Uncompensated Care program not only has a sunset provision, but it is growing at such a fast pace that it requires more than a 20% surcharge on hospital bills. We all pay this bill through higher premiums to insurance providers. There is no question that we need the safety net as provided by the Uncompensated Fund, but there is also a need to cut back on this rising cost. The taxpayers of New Jersey are subsidizing those employers who do not provide health care coverage to their employees, by shifting the cost of the employees health care on to the Uncompensated Care Fund. It seems unlikely that the Federal Government will enact the Kennedy-Waxman Bill mandating all employers to provide health care coverage. New Jersey should become the third state to enact legislation to require employers to carry basic health insurance for all its employees.

The argument against this legislation is that it will force small employers out of business or that this extra cost will prevent some businesses from competing on the world

market. These are the same arguments that have been made over the years against improving the minimum wage, against workers compensation, and unemployment insurance. The organizations that make these arguments return again and again to hold up progress in America, but examination shows that the small companies continue to grow and prosper. These statements make for good propaganda, but are not the facts.

In New Jersey, we have 158,000 firms that can be considered small businesses, that is fewer that 21 employees. If in any law passed, we eliminate for the present -- and I mean for a period of time -- any employer of three or less, we would eliminate 55% of the small firms. If we mandate coverage in cases where an employer has four employees, we are not talking about small Mamma and Papa operations. When we talk of competing on the international market, we have to understand that the larger companies provide their employees with some form of health coverage at present. Health may be a serious cost item, but the larger companies in the main do not add to the uninsured. It is in the service industries that we find the greatest number of employees with no coverage. In these cases, the general public is subsidizing the employer who provides no coverage.

We cannot wait for the Federal government to enact legislation. Each day that goes by, additional persons are being added to the list of uninsured. In those cases where employers are bound by union contracts, the cost of health care is complicating labor negotiations and causing disruption in peaceful collective bargaining.

Any law we adopt should provide that those persons that will not receive health coverage because they are not employed should be covered by a Uncompensated Trust Fund or we should establish a Health Fund similar to the Unemployment Fund to provide for the unemployed and other uninsured.

When we speak of access, we also have to examine and have the obligation to examine two areas where we supposedly have access to health care, but the administration of these programs leaves a great deal to be desired. The poor have coverage for health care under the Medicaid program, but we provide such low reimbursement for medical providers, that the poor are deprived of medical care because of the lack of doctors in their communities, and have to resort to emergency room care in case of illness. Although everyone denies double standards, we actually practice a secondary level of care for the poor. This must be corrected and in the long run will save money because emergency room treatment is the most expensive way of providing health care. To correct this situation we have to upgrade the Medicaid reimbursement to the Medicare level and encourage doctors to practice in the poor communities of the State.

The second area is the care provided the elderly and disabled. We have coverage under the Medicare program, but the system requires greater and greater out-of-pocket costs so as to cause the system to break down. When a doctor is not ready to accept the Medicare fee or to take assignment, and 72% fall into this category, the senior or disabled is then compelled to pay out-of-pocket costs, and in New Jersey those costs amounted to over $100 million in 1989. The requirement of large out-of-pocket costs is forcing seniors and disabled, just as the poor, to avoid going to doctors until the illness requires an emergency room visit, and this multiplies the cost of health care. It also impacts on the Uncompensated Trust Fund, since we no longer enjoy a Medicare waiver.

This injustice to the elderly and disabled can be corrected by passage of the Medicare Assignment legislation before the Assembly as A-3042, introduced by Assemblypersons Stephanie Bush and James McGreevey, and S-1975 before the Senate, introduced by Senator Carmen Orechio.

It would be to the credit of this Commission to call on our congressional delegation to work for the establishment of a national health program of comprehensive health care for all Americans. Lacking a national effort, it would be proper to have a New Jersey Health Care Task Force to develop a New Jersey State Health Care Program providing health care to every resident. In this way, we can reverse the trend in health care of watching out for the bottom dollar and place the emphasis on providing quality health care for everyone who needs it. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much, Al. Can we have copies of your testimony, at your convenience?

MR. EVANOFF: Yes. I have one copy only.

ASSEMBLYMAN McGREEVEY: Thanks, Al.

ASSEMBLYMAN KELLY: I've got a question.

ASSEMBLYMAN McGREEVEY: Jack. John.

ASSEMBLYMAN KELLY: You gave a figure that said 70% of the doctors don't accept Medicare payments. Is that in New Jersey?

MR. EVANOFF: Seventy-two per cent. Correct.

ASSEMBLYMAN KELLY: In New Jersey?

MR. EVANOFF: Yes.

ASSEMBLYMAN KELLY: Well, I did my own survey of doctors up in my area, and every one of them said they accept it. I'm just curious to where these figures come from.

MR. EVANOFF: Well, most likely-- What area do you come from?

ASSEMBLYMAN KELLY: Essex.

MR. EVANOFF: I think you have them lying, as thieves.

ASSEMBLYMAN KELLY: They're thieves?

MR. EVANOFF: No, they're lying. The facts are very plain. There's a book put out by Medicare, and it lists every doctor who accepts assignment on a regular basis. That's 27.8% in this State. There are doctors on the other hand, that do

not accept assignment, but will accept it for me or you or someone else who comes into their office, who generally do not accept assignment, but will accept it for individual people. There are some programs in the State which have been proved failures, and that is where doctors agree to accept the Medicare rate if the Medical Society has someone call them and that person is in the bracket of being able to collect on PAAD -- the Pharmacy Aid to Disabled and Aged -- and that doctor will then -- if he's called by the Medical Society -- accept that patient on the Medicare fee. But that's sort of a means test operation.

ASSEMBLYMAN KELLY: Do you object to a means test?

MR. EVANOFF: Yes, of course. I pay every month, just like you must pay for an insurance policy. I pay every month for my insurance, and that was a commitment in 1965, and I paid 25% of the costs. I now pay $29.60 monthly, and the government agreed to pay 75% of the costs. That was the agreement, and I expect that that would be lived up to because I believe that our government is established and lives up to its commitment to its seniors.

Therefore, I object to anyone who would look upon Medicare as a welfare program. It is not a welfare program. It's a program that's mine to have, and if I want to pay for the monthly premium for part B, I can do it on an insurance basis, and it should remain as an insurance policy.

ASSEMBLYMAN KELLY: I'm finished.

ASSEMBLYMAN FELICE: Yes, the Medicare Assignment Program -- I guess the example is Massachusetts -- how is that program working up there as far as the doctors participating, or leaving the program, or not coming into the State? Is it in any way hurting the very people that we want to help -- the seniors and the disabled?

MR. EVANOFF: I was always under the assumption that it was working well, but Governor Florio as a Congressman and a

head of a committee in Congress, asked that the government make a survey and an examination of the Massachusetts program. That report was issued approximately three months ago, and that report says that it's working fine. The doctors are providing the care both in Massachusetts and in the other three states where there is an assignment program. That's a government report that's available to anyone.

ASSEMBLYMAN McGREEVEY: Thanks, Al. Are there any questions specifically on the initial part of Al's testimony regarding the whole question of who's in charge, who's not in charge and his suggestions for alternatives to address the program? Jack?

MR. FAY: No, just that I think the figures have to be mentioned more prominently and repeated. I know my last State assignment at the Cancer Commission, this was also documented on a very very high incident rate and a very high death rate among blacks and among Hispanics in our State, much more so than say, Ohio or more so than Massachusetts. So the points that Al has made haven't been made often enough and hasn't been brought through the media -- through television the written press -- just how terribly serious this is. If we don't take a much closer look, and certainly make this that kind of a priority, to be debated of course-- It's certainly not to be treated as a casual "yes, it's serious, but we'll get to it." I don't think there's much time left to start getting to these particular problems.

ASSEMBLYMAN McGREEVEY: No other questions. Thanks Al. I appreciate your testimony, and I'm sure we'll be seeing you, hopefully on future occasions. Thank you for your time. At this time -- just so people know -- we have-- Is Karen?--

K A R E N U E B E L E: Uebele.

ASSEMBLYMAN McGREEVEY: Uebele. Karen, I'm sorry, we have your copy of your testimony, and I understand that you have to leave by 12, but we're going to continue because we're

also on a time deadline and I'd just like to note for the record that Karen's with the New Jersey Association of Non-Profit Homes for the Aging. We have your testimony, and I'll make sure it's distributed and also incorporated into the record.

MS. UEBELE: When is the Long-Term Care sector being shared?

ASSEMBLYMAN McGREEVEY: We'll be doing -- as I said on the outset -- we're going to be looking at this in six month periods. Right now, we're going to be looking at this aspect, and the next will be the DRG mark-up, and then finally, we'll be getting into the Long-Term Home Health Care Policy. I'd be glad to talk with you at some later date on the issues. At this time, I'd like to call upon Joseph Riordan for the United Senior Alliance.

J O S E P H R I O R D A N: Good morning, ladies and gentleman. Thank you for the opportunity to appear before the Committee. My testimony will be short. I think you've heard every statistic and every aspect of things that could be said about access, and that's all I want to address -- is access.

Every citizen of the United States is entitled to adequate health care, so it follows that every resident of the State of New Jersey should have access to the health care system. The reality is that more than 15% of all Americans do not have direct access to doctor or hospital services because they do not have health insurance. The percentage of uninsured in New Jersey is slightly lower. It is said that the first question asked at the hospital admissions desk, or the emergency room is, "What insurance coverage do you have?" The common sign in the doctor's office is, "Payment is expected for services provided." These circumstances cause the uninsured to forgo needed medical attention until the situation becomes more serious with resultant need for expensive high-tech

procedures. These are the kind of situations which make cost containment more difficult.

Who are the uninsured? About 60% are employed or underemployed in job situations where their employers provide no health insurance. Many of them are single parents. They certainly cannot afford the $3000 or $4000 per year it would cost to purchase a moderate health care policy.

What happens in our State when the uninsured become acute health care situations? They are not shunted aside. They receive the same quality of care as any other hospital patient, and the hospital is reimbursed. The means used is the Uncompensated Care Trust Fund, which more aptly could be called the Uninsured Care Fund. The Uncompensated Care Trust Fund is generated by assessing an additional amount to each paying patient's bill. Because most of these patients are covered by insurance through an employer or benefit fund, these added costs trickle down to become added premium costs. This, in my opinion, is simply unjust and unfair. Why should an employer or benefit fund, that provides insurance, have to pay additional premium costs to cover an employee whose employer does not provide insurance?

To cover this portion of those who do not have access, there will have to be a requirement that all employed people have health insurance through their employers. This insurance could be through a private insurer or perhaps a State plan. In either case, there would have to be some specific regulations ensuring available coverage for preexisting conditions, and positive access by all groups requesting coverage. It would be essential that these policies be developed to address cost containment, quality assurance, and efficient administration. A form of cost sharing could be considered in the program. Those employers who do not provide insurance would be required to contribute to a State plan which would be established. This

package would provide coverage for all employees and their benefits.

Remaining would be a group estimated to be about 350,000 people, including a fair percentage of children. The real makeup of this group would probably have to be determined by an analysis of Uncompensated Care Fund participants.

Since New Jersey has always been in the forefront of innovating health care initiatives, perhaps we should be looking at a system which might bring about increased availability of a Medicaid-Medicare type program? There is the possibility of a dedicated funding source to be considered.

In the five years I have been involved in the senior citizen movement, we have been trying to address the problems of those who "fall between the cracks." These are the people who, by reason of their income, do not qualify for Medicaid or PAAD, but who have pressing need in some instances, for some health care services. We continue to address these needs by the Long-term Care Campaign, which is the campaign that generated the Pepper report, and which I coordinate in the State of New Jersey. And we do have some small programs on the State level that we are looking at.

The segment of the population who do not have direct access to the health care system are often proud people for whom the present process is demeaning. They often delay seeking help which sometimes results in the need for extensive, expensive procedures. We must develop an access plan. New Jersey is the place to start. Every human being is entitled to dignity, equality, and justice in every phase of their lives.

I close by saying that in the five years I have been involved in the health care system, I have supported numerous initiatives. As I look back, I see that they were mostly Band-Aids. As a nation, we spend a greater percentage of our gross national product on health care than any other industrial nation in the world. Despite the expenditure, we rank low in

most areas of health. It is distressing to see and hear about the neo-natal cases in our hospitals, the early deaths from heart and blood pressure problems in the black population, the numerous health problems in rural areas around the country and in the inner cities. As a nation, we should be ashamed of ourselves. Some participants in the system get wealthy, but more die before their time.

The time is approaching when we will stop applying Band-Aids. In this decade, it is my belief, a universal health care system will come into being in the United States. Then, the entire population will have quality health care during their normal life spans. There may be some, who perhaps with no quality of life, will leave us earlier. However, we do believe that the status of our health care as a nation will improve. Thank you. I'll take questions if anybody has a question.

ASSEMBLYMAN McGREEVEY: Thank you very much, Joe. I appreciate your taking the time. Does anybody have any questions on specific-- (no response) No. I think the testimony that you provided was very helpful. I think it reinforces the need that clearly we have to address the gaps in coverage, and also those that have not access for their lack of insurance. I hope the United Senior Alliance, with the Care Coalition and of course, David, will be working with us in the future. Thanks for your time. The next is Ms. Maureen Lopes from the New Jersey Business and Industry Association. Maureen's fitted right between the United Senior Alliance and Legal Services, so you're in good company.

M A U R E E N L O P E S: I like being surrounded. Thanks very much for this opportunity. I would just like to-- I did hand out my written remarks, but to insert something that Commissioner Bramucci said: I really do think we need a health policy for this State. We have backed into a lot of issues.

A lot of things end up being philosophical. What percentage of our GNP do we want to spend on health care? We know it's been growing. At some point, I think we as taxpayers have to make a decision. What are our taxes going for? What percentage are we willing to pay for? I don't claim to have an answer to that, but as we know when we talk about critical issues such as homelessness, food for people, and health care is right up there, and they're difficult individual stories. I think that's what makes it difficult for all of us in this hearing.

Just to quickly review here. I also have some numbers from Foster Higgins which has been very helpful. They've been working with us to actually pull out some New Jersey numbers, so that you'll see in that first -- or second paragraph actually -- that the average health care plan in New Jersey in 1989 was $2827. That comes out of their national survey and they pulled out the New Jersey companies for us. As other people have said, there's a wide range there too. As a single young person you might pay $2000; for family coverage $5000 to $6000. I've talked to small CPA firms where $6000 is not unusual for family coverage.

One of the other things that's been touched on is what has been happening with hospital costs. I think in the past two years we were able to look at 1986 data and say that health costs and hospital costs in New Jersey were particularly low, compared to national averages. But I think you're aware from The Star Ledger articles, that we've been playing catch-up since then. 1987, 88, going into 90, there's been a lot of retroactive increases, and I think it's difficult for all of us to know right now where we stand on a national basis, but that's clearly been growing quickly. A big piece of this has been those shifts from Medicare.

I would like to ask the Committee to, if possible, get a better handle on this. We know that Medicare has been

holding down its rate of increase. What does that say about the fact that New Jersey has allowed quicker increases? So now there's a gap and that's what the Medicare shift is all about; all other payers pick out that differential. I don't have an answer to that either, but I think it's a very important part of why these costs-- Even though each piece seems to be in control, overall things look out of control.

ASSEMBLYMAN McGREEVEY: Do you know offhand, Maureen, what was projected-- I've seen different numbers that projected Federal cuts on the Medicare allocation. I've seen between five to seven billion.

MS. LOPES: That's what I've been hearing also. I intend to go to Washington next week and talk to them further.

ASSEMBLYMAN McGREEVEY: What would be interesting to see is also what impact that has, if you could, on the New Jersey Medicare reimbursement.

MS. LOPES: I know.

ASSEMBLYMAN McGREEVEY: Those projected cuts.

MS. LOPES: A couple of years ago, the shift was something like $150 million, and that's been going up also.

ASSEMBLYMAN McGREEVEY: Yeah.

MS. LOPES: So that gives you a feeling for a big chunk of what's happening with the uncompensated care after the '89 change, why it seems to skyrocket.

ASSEMBLYMAN McGREEVEY: Thank you.

MS. LOPES: It's a big chunk. And just some personal reflection here. Eighty percent of NJBIA's members have 50 or fewer employees, so although I think a lot of people have a perception that we represent AT&T, a big chunk of our members are very small. I get phone calls every week from these companies saying, "I just got my recent increase from 'XYZ' insurance company. What can I do?" And as we've talked today, there are not as many options for the small employer, as there are for the big ones.

I would argue, as I know you've heard from NJBIA before, that mandated benefits do add to these costs. I've quoted here one national study that estimates that one-quarter of the nation's uninsured are uninsured because of mandated benefits. The Maryland Legislature has evidently looked at that after several years and weren't sure that the benefits from introducing specific mandates outweighed the cost that was added onto the system.

ASSEMBLYMAN McGREEVEY: Why is that?

MS. LOPES: Because the mandates add costs across the board even though only smaller segments of the insured population may benefit from the services, so as you get more and more specific to what you're going to mandate, fewer and fewer people may take advantage of them, although for an individual it may be a significant cost item. A lot of people are paying for a small piece of benefits.

ASSEMBLYMAN McGREEVEY: But doesn't that also imply that Uncompensated Health Care Trust Fund is going to drop in cost because now you'll have people that are covered?

MS. LOPES: I'm talking more specifically about whether you mandate alcohol coverage or those kinds of things.

ASSEMBLYMAN McGREEVEY: Sure. But in terms of a certain minimum threshold, if you mandated, for example -- the discussions both on Federal and State level -- if you mandate a certain threshold minimum benefit--

MS. LOPES: Of coverage.

ASSEMBLYMAN McGREEVEY: --of coverage. I mean obviously that would reduce not only the Uncompensated Health Care Trust Fund for charity care and bad billables, but it would also reduce the costs on other corporations or good employers that do provide health care insurance.

MS. LOPES: It's quite likely to have that. What we don't know, where people have modeled, is trying to figure out how much employment we lose. So, we get real trade-offs at the

smallest companies between whether we want people employed and uninsured, or now they're out of the employment market.

ASSEMBLYMAN McGREEVEY: But somebody else is paying for that insurance though. I mean, as we said earlier, no one's getting a free lunch.

MS. LOPES: It's being paid by someone else.

ASSEMBLYMAN McGREEVEY: It's being paid by maybe the company that has 10 employees, or the man that has five employees and decides it's worthwhile to insure. I mean, it's also concurrent with, is there insurance available for those small companies, which is also an overarching problem. There are good small companies that can't even get insurance. The philosophical question is, is mandation -- if it were available per se -- is that, in your view, a wrong step for public policy?

MS. LOPES: I think we would start with, "Have we done everything possible to make it affordable--

ASSEMBLYMAN McGREEVEY: I agree.

MS. LOPES: --for small companies? I think that's what Oregon is struggling with.

ASSEMBLYMAN McGREEVEY: Sure.

MS. LOPES: Are the incentives there? And then, are we left with some proportion?

ASSEMBLYMAN McGREEVEY: Because well-intended companies, small companies, can't even get insurance because of their risk pools. I'm sorry.

MS. LOPES: That's okay. One of the things that does add to the cost of small businesses trying to provide insurance is the way the Federal tax law is set up. Now I know we can't control that in New Jersey, but maybe we could lobby our congressional staff that if you're a small business, or self-employed, you cannot deduct. Only up to 25% of your premiums are deductible. That law that allows a 25% deduction is due to expire at the end of this year. It got a one-year extension. That's a big chunk of what makes it difficult for

small companies. Also, the smaller the firm, the higher the transaction costs. It's difficult to administer it.

Also, we get back to the idea about high risk pools that if you have one or two people in a firm who are working, but have had cancer in the recent past or something like that, that makes them high risk certainly.

I have provided some recommendations. There are several states who have established boards to look at proposed legislation dealing with specific mandate laws, and I think that might be worthwhile in New Jersey. That's the whole idea of cost-effectiveness, to review that before we pass additional legislation.

We, of course, would like to see the hospital reimbursement system become more prospective, and I know you're going to be looking at that in your next round with the DRGs. And also we're looking towards the Governor's Commission to come up with a more equitable way to pay for uncompensated care. Many other people have talked about the current financing mechanism just makes the spiral worse.

ASSEMBLYMAN McGREEVEY: Before you leave that, Maureen, if I could, recognizing the deficit, what's the other way? How are we going to--. What broad based mechanism is there to spread the costs?

MS. LOPES: Well, I think as a society we decided that access to hospital care is a right that we should be willing to be taxed for that. I don't say what kind of tax, but that's the broadest base. I think we are up against a crucial point in our development that we have to recognize. That it has been a tax on many people, but a hidden tax. So, I'm sure that's one of the many things they're going to be concerned with.

We also like expansion of Medicaid. Now some of that's going to happen anyway --

ASSEMBLYMAN McGREEVEY: I agree.

MS. LOPES: --because it's much more cost-effective actually to get people into managed care, Medicaid, then to--

ASSEMBLYMAN McGREEVEY: I agree, there has to be expansion of Medicaid, also, to recoup the Federal dollars.

MS. LOPES: Yes, exactly. Until they stop that. Until they figure that one out. We also very much like this idea about creating pools of small businesses. We've had a very tough time getting information on why there aren't more of them in New Jersey. We would like to ask you to work with the Department of Insurance to find out if there are regulations that make that difficult. Other states seem to have many more of these pools built around business associations or business groups.

Now the South New Jersey Chamber of Commerce has recently pulled one together, so they might be able to be helpful. One of the other things that's come out of other study groups is that the Garden State Health Plan now exists as a public HMO, originally set up for Medicaid recipients. But if there could be a way for small businesses to buy-in some kind of sliding scale, particularly if they were service companies that had low wage earners, that would get people into a managed care program. To some extent, the providers already exist, the groundwork's been done for that, so that might be an additional cost effective mechanism for small employers.

ASSEMBLYMAN McGREEVEY: How would that work, Maureen?

MS. LOPES: Well, you'd have to specify. I really see it as if you were an employer of five or under -- which is a big chunk of our employers in this State -- and the average wage of your employees was $8.00 an hour or something like that, that between you and the employee, you could buy into -- become a part of that HMO essentially.

Now to the extent that the State has already underwritten the establishment of it and a lot of the up-front

costs are gone, it should be a fairly cost-effective way for those companies to get in.

ASSEMBLYMAN McGREEVEY: Interesting.

MS. LOPES: What we want to be careful of here of course, is not to set up a lot of competition with the HMOs that already exist, but I think there's a market there. And then finally, we think we need to look at these high risk pools. It's been a mixed answer from other states. I think we can learn from the mistakes they made, underfunding, and we know what happens with high risk pools like that. We don't want too high a percentage of the insured population in there. But again, if you can take out the one or two people of a 10 person group who are high risk, and make the premium for everyone else go down--

ASSEMBLYMAN McGREEVEY: But then we come back to the initial question that we asked, "Who pays for that?"

MS. LOPES: That may be a better place to put a broad-based tax.

ASSEMBLYMAN McGREEVEY: I just would like, if you could, work with Robbie in terms of getting information from the Department of Insurance on the Multiple Employer Trust because I think it's an important question for the industry and for business. Any questions from the Committee?

ASSEMBLYMAN FELICE: Just briefly. On the small business-- I have a particular case in mind that I'm associated with. Less than 30 to 35 employees, and they certainly gave their employees every effort to give them health insurance. Because one of the employee's children had some very very expensive operations that totaled over one half million dollars. In that group, the rates for the whole group went up tremendously.

So, without some kind of pool arrangement for small businesses-- In fact the company which I am very close to had to go out and change insurance companies to try to lower the

rates so that they wouldn't have to really increase the costs of the health insurance for the employees. So there's a problem where one individual out of 25, or 10, or 30, if they have some very expensive health care costs, then just like your insurance policy: have an accident, the next year your rates are going to go up. This is the one thing that small businesses are very concerned about. If they have an extreme high risk individual and they're practically out of business or have to say to their employees, now you're going to share the costs.

ASSEMBLYMAN McGREEVEY: Exactly. It kills them.

ASSEMBLYMAN FELICE: And that's one point.

ASSEMBLYMAN McGREEVEY: Monsignor Kelly.

MS. LOPES: You may find that people aren't being hired either.

ASSEMBLYMAN KELLY: No questions.

MS. LOPES: That's certainly not legal, but--

ASSEMBLYMAN KELLY: Well yes, it worked with less people.

MS. LOPES: --we don't want to set that situation either, where the person's health history -- going back many years -- can be tipping the hiring decision.

ASSEMBLYMAN McGREEVEY: Yeah. Any questions?

MR. FAY: Just one question. Has anyone given you the rationale why the income tax deduction would be set in such a way to hurt the small businesses?

MS. LOPES: I don't know why it was originally. I know why they're not willing to change it now: because it would reduce Federal tax income. So Congress kind of keeps it going along at only 25%. I don't know what the original rationale was. Maybe at the point it was instituted, there weren't that many small companies with health insurance, and it wasn't such a big issue. We've come full circle on that.

ASSEMBLYMAN McGREEVEY: Maureen, thank you very much for your testimony. It was very helpful and NJBIA should be complemented for having you on board.

MS. LOPES: Oh, thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much for your time.

MS. LOPES: I'll really work with Robbie. I appreciate that opportunity.

ASSEMBLYMAN McGREEVEY: Thank you. Next is Leighton Holness from Legal Services of New Jersey.

L E I G H T O N H O L N E S S, ESQ.: As representatives of poor people, Legal Services of New Jersey welcomes this opportunity to express our concerns about access to health care in New Jersey. We are particularly concerned with the need for Medicaid expansion and with the future of New Jersey's Uncompensated Care Trust Fund, the State's most important program for assuring access to hospital care for poor people.

New Jersey law recognizes the reasonable cost of uncompensated care as an element of cost which must be included in hospital payment rates charged to purchasers of hospital services. The Uncompensated Care Trust Fund now spreads the cost of the uncompensated care evenly across hospitals in the State thereby preventing "patient dumping," always a temptation if each hospital was left to collect through its own rates the fund to pay for its own uncompensated care.

Hospitals must provide uncompensated care largely because many people don't have health insurance. These are usually poor people. Approximately 25% of New Jersey residents with a family income below the Federal poverty level don't have health insurance. About one fifth of all New Jersey residents without health insurance of any kind have family income below the Federal poverty level.

It is therefore extremely important to expand Medicaid eligibility to the maximum permitted by the Federal

government. The Federal government would match every dollar New Jersey spent on Medicaid. Moreover, expansion of Medicaid eligibility would in many ways work to restrict the growth of uncompensated care.

In enacting the most recent version of the Uncompensated Care Trust Fund law, the Legislature mandated the Trust Fund Advisory Committee to explore financing options for the Fund other than the current method of marking up hospital charges. The Trust Fund Advisory Committee, in developing alternative financing arrangements, "recognized the importance of maintaining the hospital uncompensated care markup as a fallback financing mechanism for any residual uncompensated care -- in the event other funding sources being implemented fall short of expectations in a given year, due to subsequent legislative action or inaccurate revenue or uncompensated care cost projections."

Legal Services of New Jersey emphatically endorses this statement. It is the only way that all hospitals continue to provide uncompensated care to those who are eligible and are equitably reimbursed for doing so. We note that the former Commissioner of Health specifically recommended the retention of the hospital markup system as a safeguard in the event that other financing mechanisms are not adequate to fully fund uncompensated care.

The Commissioner of Health also noted, and we agree, that if the Trust Fund Advisory Commission's recommendation for an initially reduced markup is accepted, this would result in reductions in State spending for the Medicaid program and the State Employee Benefits Program. She suggested that the State's portion of the Medicaid expansion could be fully funded by the savings to the State resulting from the lowering of the hospital markup. Legal Services of New Jersey is of the view that if alternative financing is introduced and does result in reduced costs to the State, as well as other purchasers of

hospital services, the savings to the State should be applied to the cost of expanding Medicaid eligibility thereby attracting matching Federal dollars.

ASSEMBLYMAN McGREEVEY: Thank you very much. Any questions? Assemblyman Cohen.

ASSEMBLYMAN COHEN: Is patient dumping-- Do you have many complaints?

MR. HOLNESS: No, we have no complaints at all. We want to keep the system that we have which effectively avoids that problem. That's one of the initial purposes of the Fund. We are concerned that that be kept in mind at this point.

ASSEMBLYMAN COHEN: I was, at one time, State Ombudsman for the Elderly. We had found a serious problem of dumping from the inner city hospitals into boarding homes where they didn't have a family, they didn't have someone observing them. You're telling me that you don't have any particular cases.

MR. HOLNESS: We are not aware of any complaints of any serious kind about that. One reason for it, I think, is the role of the Fund at the present time.

ASSEMBLYMAN McGREEVEY: The other thing Mr. Holness, I just want to thank you. I appreciate your comments regarding the increased eligibility for Medicaid. One of the things I think at some point we have to look at is, where Medicaid enrollment begins, perhaps with AFDC. An earlier point in the system such as to encourage utilization of Medicaid and ensure the match of Federal dollars. We look forward to working with you in the future. Thank you very much.

MR. HOLNESS: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you for taking the time. It gives me great pleasure-- Murray, is he back in the room? (no response) Murray Bevin from the New Jersey Hospital Association.

M U R R A Y B E V I N: Mr. Chairman, Assemblymen, and Mr. Fay. Thank you for giving me the opportunity to comment today. Let me begin by applauding you and the Assembly leadership for creating this Committee. You are in fact tackling probably some of the toughest public policy problems that I can think of of this decade. Incredibly difficult, incredibly complex.

I want to indicate today that the Hospital Association stands ready to work with you in those deliberations, and to participate fully in all of them. I am particularly pleased to note, ASSEMBLYMAN McGREEVEY, that you will in fact look at the diagnostic related group issues and really the whole system of hospital rate setting; one that we believe is overly complex, that in fact makes appeals the rule, rather than the exception.

As Assemblyman Impreveduto indicated earlier about some of the costs, one of the problems of the rate setting process is it's not timely. We're still working on 1986 rates, so in fact 1987, 1988, 1989 need to be absorbed at some point. We've taken the position -- I think a lot of the data will bear it out -- that hospitals have been very aggressive as has the Department of Health, in holding down the health care costs and hospital costs. But you still have an enormous problem coming at you like a freight train in terms of regulatory lag which needs to be made up for figures to be current.

Finally, I would note that the process is not as reliable as it ought to be. However-- What the topic that you would like me to address today, in fact, is the uninsured and the underinsured. Rather than repeat a number of the statistics and a number of the facts that individuals so ably did before, let me just give a piece of the hospital's perspective, probably on uncompensated care which is really where the uninsured and the underinsured do, indeed, come in.

As Commissioner Bramucci indicated, we probably did back into this uncompensated care plan. When you look at the

proposal when it was developed in '85, '86, you had a hospital surcharge which now is 10.8%, which was around 4% or 5%. In fact, I have an old newspaper article somewhere in here that indicated this 5%. Part of the problem of that was the pullout of the Medicaid waiver which has drastically increased the cost of the overall fund. Thirty-five or 40% of those costs have, in fact, shifted. It was probably was a manageable system and the surcharge probably could have been a manageable mechanism, if you hadn't had the Federal government not contributing its full fair share.

Unfortunately, as we watch what happens from Washington and with the President proposing another 5.6 billion dollars in that fund this year, the future of it is continued growth in cost obviously, and continuing less funding on the Federal level, so the gulf just continues to get wider. Because of that, I think we need to look at some alternative funding mechanisms, and surely a number of them have been discussed today.

The Hospital Association has always supported a concept of the broadest base methods as possible. Those could be general revenues, those could be sin taxes. There could be a number of alternative ways of financing it. Clearly our position, however, is that the fund is worthwhile. It is an appropriate thing for a compassionate government to, in fact, do. We think that the fund should be guaranteed and should be continued. Obviously what we need to grapple with, what we need to wrestle with, and what you will be deliberating on is, what is the best way of funding it?

Clearly the indication is that funding is that 41%, 42% of those in the Uncompensated Care Trust Fund are, in fact, employed. When you add dependents to that number, you clearly get a majority of individuals in that fund that are employed. I have hired a new secretary today, in fact, in my office. She's been employed for six years since she left college. One

of the questions I asked her in an interview last week is why are you-- The salary is about the same here. She said, "Well, you have medical benefits." This is a person who has been employed for six years in the State of New Jersey who has never had medical benefits. I found that kind of extraordinary. She said, "Gee, I'm one of your statistics that you're going to talk about." I said, "Absolutely."

It's a problem. Clearly, it's a growing problem.However, if you were to address some sort of a benefit and some sort of a coverage program, and assuming that you could get at that $600 million figure, you probably could make a major dent in it by addressing the issue of insurance, and insurance for individuals.

NJHA is not unmindful of the effect that some sort of mandatory coverage process would have on small business. We're aware that it can impact on competitiveness of businesses. We're surely aware that labor sees these benefits as things that were heard bargained for in a collective bargaining process. To have that in fact -- a portion of that thing go towards care for someone else, is something that's difficult in the process. However, I want to echo I think what a number of people have indicated in the testimony today, that through your efforts -- through a coalition of efforts through business, and hospitals and State decision makers -- I think that we can come up with some solutions, some innovative approaches. I have a number of things listed here of the programs that many of the others have talked about and I won't go into them, but I'm optimistic that if we work collectively to tackle this tough issue, that we can do it. We look forward to being a part of this process.

ASSEMBLYMAN McGREEVEY: Thank you, Murray. And just for myself and also the Commission members, we also look forward to working closely with you on the second phase as well as the third phase of this Commission's charter.

In subsequent hearings, we'll be talking and we'd look to the Hospital Association for having specific numbers on three items: 1) the whole question of the amount that's expended, the average amount that's expended for uncompensated health care, and the reimbursement level from the fund, 2) the practice of hospitals of pursuing bad billables, people who don't pay their insurance, and basically our hospitals are doing all that they need to do to collect on those dollars, and 3) I think that marriage looking is the impact on not only the insured, but also on the DRG reimbursement system. How can we, if at all possible, expand those rate settings to include perhaps some of the poor and some the indigent, if that's appropriate?

MR. BEVIN: Yes, we'd be glad to provide those. I want to provide you with one piece of data, one figure, and I think it was discussed a bit this morning, that puts New Jersey hospital costs in perspective in terms of overall costs. We have the third highest per capita income in the State of New Jersey. We are 31st in the country. In other words, 30 states spend more for hospital costs than we do. When you put the two of them together however, New Jersey hospitals are 50th in the country in terms of cost as a percentage of per capita income.

Some allusions to hospitals doing a reasonable job in holding down costs, I think you couldn't do a whole lot more. In fact, 37 of the 189 acute care hospitals, last year, ran in the red to over a tune of $50 million. That's an issue that I think needs to be addressed obviously at the other side of the equation.

ASSEMBLYMAN McGREEVEY: And we'd also like to look at insurance companies not reimbursing the discrepancy between the billable and what is insured and the whole process of making sure the hospital is gets what it is just due from the insurance company in those regards. We'll do that for another day. Does anybody have any questions as to the impact?

MR. FAY: I have one question, Assemblyman. Is this unique or is it a trend? What I see in Elizabeth, New Jersey where the former Alexian Brothers Hospital, I think they just went over to Elizabeth General, and changing over to long-term care beds or turning over to a nursing home type of-- Is that unique, or is this something that is happening everywhere?

MR. BEVIN: I don't think it's unique. It is happening in other parts of the country. We suspect that you probably won't see a lot more of that, in fact, in New Jersey.Although there could be some examples of it, it's not always a perfect match to rehab a hospital into a long-term care facility. In addition, New Jersey has the third highest hospital occupancy rate in the country.in terms of beds. So, there is not the overcapacity problem that might exist in some other states.

MR. FAY: Are the county hospitals part of your Association, or, are they separate?

MR, BEVIN: We represent all of the hospitals in the State, yes.

ASSEMBLYMAN FELICE: Just briefly on that. In your future discussions and reports, the very same thing goes, those hospital beds, those hospitals that do have a percentage of empty beds which actually are not going to help the overall costs. What direction are they thinking of going in, to utilize those beds; we'd like to know in any future reports that you have.

MR. BEVIN: Sure. We can surely detail that. I suspect that in some of those areas with increasing age population, with increasingly elderly population, that you may find some hospital planners just say five years down the road, New Jersey might not have enough beds, in fact, which is very different than the trends in other parts of the country. Bed utilization is not a problem for New Jersey.

ASSEMBLYMAN IMPREVEDUTO: Mr. Chairman, just one quick-- I guess my question is, do you know what the number is for the daily average cost of a patient in a hospital on an overnight stay?

MR. BEVIN: I don't have it on me. We do have it. I probably ought to know that, but I don't have it. I could get it for you.

ASSEMBLYMAN McGREEVEY: Could you also, Murray, perhaps-- When we're looking at the impact of the dollar, if the Hospital Association could afford specific policy recommendations both as to looking at the Medicaid shortfall, looking at the whole question of mandatory benefits-- What we're also interested in getting ahold on is two sides of the same coin: One, hospitals are being accused perhaps wrongly, perhaps correctly, of inflating charges for the Uncompensated Health Care Trust Fund, and some are accused of the proverbial milking the system.

The inverse of that is certain hospitals are claiming that insurance companies, say for example on the hospital bills of the insurance company, the insurance company may debate the correctness of the utilization of a procedure and not reimburse the hospital for any aspect of the medical care or the hospitalization provided.

I'm also looking for the Hospital Association to provide information that they think can provide safeguards, both checking the hospitals' use of the fund as well as, safeguards on the insurance industry guaranteeing that perhaps there be a presumptive payment from acute care hospital facility settings.

MR. BEVIN: We'll be glad to.

ASSEMBLYMAN McGREEVEY: Okay. If at all possible within the next two weeks. By the end of this month, that would be appreciated. Thank you. Seeing no other further questions, thank you very much. We have a woman from Rutgers

University, a retiree. Thank you, Oliver. Taisa Scors just would like to testify.

T A I S A S C O R S: I have rather a unique case. I got in a triangle with legislation. I am a Research Librarian for Biology and Medicine at Rutgers University Library of Science and Medicine. I am responsible for the Medical School budget completely; periodicals and books, also, biology acquisition and reference. I have worked with Rutgers since 1966 when it was announced building of Medical School. I started that date.

I am coming just now to 70 and the legislation of New Jersey and Rutgers is calling for my retirement. It means I will be missing just six months to complete 25 years working with Rutgers. I applied-- By the way, the rule already overturned. I went to AUP and they told me the second half of 1992, you can work until 105. Well, but it is not applied to me. I asked for exception because Rutger's rule -- I have a copy of it saying -- with recommendation of your supervisor, you can be granted another year or a particular contract to finish your 25 years. For me, 25 years is important because it gives me free benefits.

ASSEMBLYMAN McGREEVEY: Health care benefits?

MS. SCORS: Health benefits.

ASSEMBLYMAN McGREEVEY: So, without those 25 years you don't get the health care benefits.

MS. SCORS: Yes. If I miss six months, which I am actually missing, I am losing everything, and I feel it's just no justice because I contribute very much my own time, and my effort to Rutgers University. I came when the building was under construction. I gathered on third floor all donations, from Squibb, I purchased from abroad. At that time I was head of the periodicals department, so actually what drugs it has, it was me. I had only one clerk. Now they have three clerks with everything done.

ASSEMBLYMAN McGREEVEY: You're too efficient, Taisa.

MS. SCORS: Yeah. So, I applied to Dr. Pond asking him to give me an extension for six months. I have here 35 letters testifying that my job was excellent, including McGreevey, and Medical School Dean Preson, Ex Medical School Dean, Faculty Medical School Chairman, Medical School Chairman of Biology Department of Rutgers, Chairman of Graduate Program, all faculty, all my colleagues, and I was denied. Just now in Brussels our people will be writing a letter to the Board and they are very much upset about it. But they made, you know, the same turnover. So this is one rule which I cannot use.

And the second possibility, I went before that Board, State University of New York, Downstate Medical Center, in Brooklyn on Claxson Avenue, you know the county hospital. I worked for nine years at the State University, as you know, and I have here saying my benefits will be given me, but I-- It was ruled last year that if you are missing at the present time at Rutgers one or a few years, you can borrow if you worked before for a State institution, even in another state. I was very very happy last year when I heard, but this year when I came to the meeting they said, "Oh no, this was Public Health." This is (indiscernible) and it's no concern.

So you see, I am in a triangle. I can use this rule, I cannot use this rule. For me this is important because I am a widow. My husband worked with Hercules Powder Company in research with benzene and he was a victim of leukemia. I submitted to court, a computer search on leukemia and benzene, but the institution gave us four lawyers which I couldn't afford and I lost.

MR. FAY: Did Dr. Pond or Dr. Bergen give you any specifics as to why they would not allow this waiver for six months?

MS. SCORS: No, just recently I know they didn't give me any. You see what I got, correspondence from my supervisor at Library of Science and Medicine completely supporting me. She wrote a third letter. It's a very bad case.

MR. FAY: How about your association there? Your professional organization?

MS. SCORS: AUP supports me. Everybody is supporting me, absolutely everybody. But who is the support? We have the Director of Libraries, she got a little promotion, so she's trying to move up. She is trying to cut the budget. Rutgers has a very bad case of budget, so she wanted to present administration that she is cutting so much. Actually, what she cutting? She's cutting my head because half a year-- I would provide much better service than if my duties were spread among different people. Because I have medical school training, I have eight graduate credits from the Institute of Microbiology-Waxman, during the Waxman time, I was a school physician's aide in New York, I have thirty-five years experience in medicine. The Dean, when I came to medical school, said Taisa, we support you. But, one time the supervisor, at the Alexander Library in New Brunswick, she said, "Well, that's good for you but we can replace you by younger person." Certainly, we all can be replaced. I am sure all of us can be replaced by a younger person. Dr. Bloust and I, he will be replaced.

MR. FAY: He was.

MS. SCORS: There is no question that somebody cannot be replaced. I certainly can be replaced, but it takes time. At the present time we are very short of personnel. We have two positions and if I retire it will be number three. My question to give me an extension for six months or to give me at least my benefits. I think I am entitled to them. I work very hard.

ASSEMBLYMAN McGREEVEY: Thank you, Taisa. Just so that everyone knows that the Commission provided an opportunity for her to-- To me it was real gut -- and not a question of decency and we-- Unfortunately we wrote to the Dean, we wrote

to the President, we wrote to the Board of Directors, and they have all turned her down and--

ASSEMBLYMAN FELICE: Couldn't she go on a medical leave for six months?

ASSEMBLYMAN McGREEVEY: Yeah, I mean it's a matter of--

ASSEMBLYMAN FELICE: Get sick and get a medical leave for six months.

ASSEMBLYMAN McGREEVEY: I don't think that's an official recommendation.

MS. SCORS: I think it is discrimination not only age but, yes, age because they ask you to get letters, supportive letters, but the difficulty is I am in pretty good physical and mental condition. When I ask somebody to write supportive letters, the person asks me, "Are you really 70?" I think it's a very unpleasant experience.

ASSEMBLYMAN McGREEVEY: I just appreciate your taking the time to come here today. I think it's one thing that the Commission will work on in the Assembly, and Dr. Felice will be willing to sign that note-- (laughter) No, but it's something in all sincerity that we'll work on. I appreciate your taking the time to come here because it's important to me, and it's obviously important to you.

ASSEMBLYMAN FELICE: Absolutely.

MS. SCORS: It's very important.

ASSEMBLYMAN FELICE: And there are other cases very similar to this. Yours is not the only case, unfortunately. There are other cases. People in other fields, professional fields, and otherwise that might -- by a lack of a few months or even less -- are being hurt. There should be sort of a program in there to give you some kind of retroactive time period. You're right, I think you have time in another state. We are considering bills on that same order, so I think that's something. I appreciate your concern and if I could change my

status from being an engineer to a doctor, I probably would hurt the system, but off the record, I would give you that time.

ASSEMBLYMAN IMPREVEDUTO: Yeah, I just needed to understand. You're being forced to retire because of your age? Or is somebody cutting your program out?

ASSEMBLYMAN FELICE: Age.

MS. SCORS: Age. No, age because I am just now 70, just this month. They have ruled that you have to retire June 30 of the same year when you turn 70. This is mandatory retirement. It is, by the way, not only Rutgers, but the State. But it overruled already, it is--

ASSEMBLYMAN IMPREVEDUTO: Now, if you were in the public school system in the State of New Jersey, years ago, at 70 you had to retire. Today you can work forever. There is no rule that says you have to retire.

ASSEMBLYMAN FELICE: No, no, no, no. Not in the State, not yet.

ASSEMBLYMAN IMPREVEDUTO: Not in the State institutions, but in the public school system there are.

ASSEMBLYMAN KELLY: I don't know about in the public school system, but in the State you have to get out.

MS. SCORS: State, yes. You see, I am on faculty and faculty have their own, like you have.

ASSEMBLYMAN KELLY: I wish Dr. Bergen would testify for appropriations, I'd rip his heart out for you, but then-- (laughter)

ASSEMBLYMAN McGREEVEY: Thank you very much, Taisa.

MS. SCORS: Please help.

ASSEMBLYMAN McGREEVEY: We just have two more people who are going to testify. One is David Keiserman, a good friend from the New Jersey Council of Senior Citizens. And last is Gordon F. Boals, unless there is anyone else who would like to testify. David.

D A V I D K E I S E R M A N: I'll be very brief. I just want to bring a couple of things, believe it or not, that were not mentioned today. I'm not going to address the problems that were. I wish I had answers for them.

Even though seniors do have insurance like Medicare, many of them cannot afford to use it because of the copayments and the additional costs that they have. I'm very happy to say that you have bills, that you're a sponsor of two bills, which I am very happy about. A-3042, which addresses Medicare assignment and the other A-944, which is-- Actually that is the primary problem with seniors -- is a proper home health care program.

ASSEMBLYMAN McGREEVEY: Yes.

MR. KEISERMAN: Right now, we only have home health care programs that reach $8000 to $21,000 for a couple, $18,000 for a single person. That's the expanded CCBED Program. If you've got a dollar over that, there's nothing. You come out the hospital quicker and sicker as you do today under DRG, and there's nothing you can turn to. Even if you need $100 worth of care and you cannot get it -- you don't have that $100 for it -- there's nothing for you. What we've been striving for and your bill also -- which by the way, was held up in the Assembly for a year-and-a-half after the Senate passed it -- was a home health care program.

A pilot program that was sponsored on the Senate, S-371, to now. Your bill, A-944, is not a pilot program that you're sponsoring, but seniors need these bills desperately, because what happens is when a senior does come out of the hospital and needs nursing home care, and slightly over that figure -- no matter how little over it -- there's nothing for him, and he winds up going into a nursing home, loses his home, loses everything, and winds up--

ASSEMBLYMAN McGREEVEY: That's far more expensive.

MR. KEISERMAN: --going on Medicaid eventually. If there was some kind of help on a sliding scale -- I don't say give it all free -- on a sliding scale-- That's what these bills have been doing. It's been laying in the Assembly for the last year-and-a-half last session, and it's starting all over again. This is the primary goals of seniors. So that's a problem we have that hasn't been addressed yet. I'm just trying to stay away from everything that has been addressed. But this also is very important to us. And thank you for sponsoring these bills, by the way, Mr. Chairman.

ASSEMBLYMAN KELLY: Do you object to a means test also?

MR. KEISERMAN: Beg your pardon, sir?

ASSEMBLYMAN KELLY: Do you object to a means test also?

MR. KEISERMAN: On what?

ASSEMBLYMAN KELLY: On anything.

MR. KEISERMAN: On anything, no. I said a sliding scale. I didn't say a means test. My objection to a means test is if you're one dollar over it, you're not entitled a damned thing, whereas if you're under it by one dollar you can get everything. That to me is all wrong. I say a sliding scale, yes; means test, no. There's a big difference between the two, sir.

ASSEMBLYMAN McGREEVEY: Thank you, David. And I also appreciate the fact that you mentioned that if we don't pay, if we don't subsist in terms of Medicare, and don't expand-- I mean we're facing all the costs in terms of Medicaid.

MR. KEISERMAN: To go a little further into that, the Federal government under Medicare, has put in this new relative value scale payments to doctors, which are much fairer than they have been up to now. Even the AMA has accepted a partial Medicare assignment type of thing that's being phased in from 1991 to 1993 where the doctors will be limited to the amount they can overcharge.

Instead of us being in the forefront, which New Jersey has always been, right now we're way behind. The least we could do is at least catch up.

ASSEMBLYMAN McGREEVEY: Thank you very much.

MR. KEISERMAN: Thank you very much.

ASSEMBLYMAN McGREEVEY: Any questions? (no response) Thank you, David. The last one is Mr. Gordon Boals. Thank you very much for your patience.

G O R D O N F. B O A L S, Ph.D: Members of the Assembly Health Care Policy Study Commission, my name is Gordon Boals. I am a licensed psychologist and I am representing the New Jersey Psychological Association. We are grateful for your interest in health care and insurance matters and for the opportunity to present to you some of our concerns.

Mental illness affects one person in 10 in our population. Providing treatment not only relieves the pain and suffering, but provides many other social benefits as well.

1) Successful treatment allows people to return to the work force or to become more creative and productive. Their higher earnings generate tax dollars and reduce social welfare costs. In addition, studies show that psychotherapy reduces absenteeism, employee turnovers, and accidents.

2) Secondly, psychotherapy has been shown to reduce other medical costs. As many as two-thirds of all visits to doctors are estimated to arise from emotional problems. It is a truism today that stress, and maladapted ways of coping with it, such as alcohol and drug abuse, aggravate medical problems.

Outpatient mental health expenditures are usually estimated as constituting only 3% of health expenditures, a very small proportion indeed. And they are not implicated in the rapid increases in health expenditures because they are wage costs; most of the increases in health expenditures are

capital costs due to expensive new machinery and hospital buildings, nor are they particularly affected by the explosion in malpractice insurance rates. Those rates have remained stable and very low in the mental health field.

Consequently, mental health expenditures should not be viewed as part of the problem of soaring health costs; rather, as suggested before, they should be viewed as part of the solution. It would make no sense to reduce mental health expenditures to control health costs. In fact, an increase in mental health expenditures is more likely to lower total health costs.

How should mental health care be financed? There are two basic options:

1) treatment can be publicly funded through taxes and be delivered through mental health clinics and community mental health centers, or

2) it can be funded privately through health insurance plans supplemented by individual copayments.

The existing problem of budget deficits makes the former approach -- publicly funded clinics -- impractical. Furthermore, since Federal support to community mental health centers has ended and they are now expected to be self-supporting, a major source of revenue for these clinics has been medical insurance benefit payments.

So, if private health insurance appears to be the most reasonable and practical way of funding mental health treatment, what problems exist with such funding, and what can be done to guarantee appropriate care for all citizens to mental health care? First, since not everyone is employed or has health benefits, there is a continuing role for publicly funded mental health clinics which will treat people, regardless of ability to pay.

Secondly, it is necessary to set minimum standards for mental health coverage in private health insurance plans. At

present, insurance companies competing to offer lower cost health insurance and employers eager to reduce their costs may cut mental health benefits to little or nothing in the expectation that employees may not complain. A personal illustration that I found when I became self-employed was that virtually every plan that is offered for the self-employed, and even group plans for the self-employed, do not cover mental health benefits. Even where benefit packages are determined by collective bargaining between workers and management, mental health benefits may be traded away for other items. It's not always easy for consumers to speak up about how important mental health treatment is to them. As I stated before, society has an interest in having mental health care available and affordable to those who need it. So, it is appropriate to set minimum levels of treatment and maximally accepted levels of copayment which should be provided in all insurance plans. Optimally, mental health should be required to be reimbursed at the same rate as other illnesses which is not usually the case.

There is precedent for this approach of mandating minimal levels of care in the reimbursement of expenditures for pregnancy and childbirth. At one time, all medical expenditures related to pregnancy and childbirth were excluded from health insurance on the grounds that these were voluntary expenditures, and pregnancy was not a disease. But then society decided it had an interest in having healthy babies and most states required all health insurance plans to cover pregnancy and childbirth.

So too with mental health benefits. Many states have mandated minimum levels of mental health care that must be reimbursed under health care insurance. But not New Jersey. We would like to see minimum levels of mental health coverage mandated in this State as well, to guarantee that all workers would have access to a satisfactory level of mental health care.

And basically, the point I'm making here is that most of the discussion today has been about percentages of people who are covered by health insurance, but what has not been looked at is the fact that not all health insurance plans cover everything. The point was made earlier about they don't necessarily cover bone marrow transplants, a very expensive thing; but increasingly, they're not covering any out patient mental health either. That is not very expensive and it is not a rising big part of the health costs.

We feel that if you just try to get people covered by health insurance and you don't look at setting minimum standards at what kind of health insurance they are going to be covered by, mental health is something unfortunately that will traded away.

ASSEMBLYMAN McGREEVEY: Doctor, that will be the focus of another hearing within these five part hearings. Today we're just trying to get a grapple on-- I appreciate your comments on who is insured and who isn't insured and the impact that that has. But the question -- as you mentioned -- as to what is covered, is obviously critical.

MR. BOALS: Okay. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you for your time and your testimony. Are there any questions?

ASSEMBLYMAN KELLY: No.

ASSEMBLYMAN McGREEVEY: Thank you very much. Do you have any extra copies of your testimony?

MR. BOALS: I gave--

ASSEMBLYMAN FELICE: We have copies.

ASSEMBLYMAN McGREEVEY: Okay. We can make another Xerox copy. Thank you very much. Is there anyone else who is interested in testifying? (no response) I'd like to thank Jack, I'd like to thank Tony, Monsignor Kelly, Nick, and Robbie for their attendance, and I'd like to thank everyone here for

attending. What we'll be doing is obviously-- This hearing is going to be transcribed. Pursuant to our feedback on this hearing, we'll then be able to plan for the next hearing which will be continuing looking at the question of insurance and will then go into the question that the Doctor raised on the scope of that coverage and its impact on the hospital as well as, obviously, the consumer of health care. Thank you very much for your time and attention.

(HEARING CONCLUDED)

APPENDIX

REMARKS OF COMMISSIONER OF LABOR RAYMOND BRAMUCCI BEFORE THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION, APRIL 16, 1990

Chairman McGreevey and Commission members (Impreveduto, Menendez, Mattison, Cohen, Felice and Kelly), thank you for this opportunity to talk to you about what I consider to be one of the most critical issues confronting the State of New Jersey today. I commend you for taking on this very complex and difficult task. It is a task that must be taken on, however, since it is clear that current health care policies are not working. In fact, they have created inequities and distortions in the marketplace that are becoming intolerable and cannot be allowed to continue.

Let me begin by addressing the matter of health insurance coverage for those in the work force. Though available data are

IX

fragmentary and somewhat dated, they do enable us to sketch out a general profile of those who have insurance protection and those who do not.

The good news has been that the vast majority of adult workers in New Jersey have had at least some kind of health care protection, either under insurance plans provided at the workplace or through policies purchased directly by the workers. According to a Department of Health analysis based on U.S. Census Bureau household survey data, about 89% of the State's employed workers aged 18-64 had coverage in 1986.

This finding is reinforced by U.S. Bureau of Labor Statistics surveys of medium to large business establishments conducted at various times from 1986 to 1988, which reveal coverage rates for full-time workers ranging from 91% in the Newark metropolitan area to 95% in Mercer County and the Bergen/Passaic County region. Most of these workers were protected by major medical coverage in addition to basic

hospitalization and surgical benefits. In the large majority of cases, this coverage was fully paid for by employers.

The other side of the coin is that about 11% of New Jersey's employed workers aged 18-64 were without health care protection in 1986. I expect that this figure has grown substantially.

Historically, gaps in health insurance protection were most common among young workers, those who work part-time and the working poor who earn too much to qualify for Medicaid but too little to afford health insurance. Workers without coverage, who accounted for about 65% of all uninsured persons in the 18-64 year age group, were most heavily concentrated in the smaller service and retail establishments where employer-financed coverage is considerably less prevalent. Since these are the sectors where jobs have been growing most rapidly, there may well have been an increase in this percentage of workers without coverage since the Health Department study was done.

Though a majority of workers enjoy some kind of health care insurance while employed, their situation can change dramatically if they become unemployed. Workers unemployed for a short period of time may remain covered by their employers' plans, but after a month or so most of them will have lost their employer-financed protection. COBRA enables them to continue their group insurance for a while at their own expense, but few rank and file workers can afford today's sky high premiums. Unless they can be covered by the insurance of a spouse, many jobless workers soon find themselves without protection.

A survey of unemployment insurance claimants conducted by my Department in 1986 revealed that only 52% of them were protected by health care insurance despite the fact that many had been unemployed for only a short period of time and were still covered under their employers" plans. About 76% of the same sample of claimants had been covered by some kind of insurance prior to their layoffs. The loss of coverage would, of course, have been much greater if

4X

the survey had excluded those on short-term layoffs.

These and other gaps in health insurance coverage represent an obvious problem for 800,000 or more New Jerseyans who lack protection as well as for health care providers and the public at large. It is a problem across the country that ideally ought to be addressed in a comprehensive manner at the national level. We cannot wait for that, however. We have been forced to deal with it at the state level and, unfortunately, we have not been doing a very good job of it.

I expect that Governor Florio's intention to establish a Commission on Health Care in the State will, in cooperation with groups like this one, begin to point the way to a much more effective means of addressing this most complex problem.

The most glaring example of our present failure is the manner in which we are financing uncompensated hospital care. I applaud the compassion of a state that makes

it possible for anyone to obtain hospital care without regard to their ability to pay. It makes no sense to me, however, to dump the cost of indigent care on employers and individuals who have had the foresight to purchase health care insurance.

As you know, the uncompensated care surcharges have accelerated what was already a steeply rising trend of health insurance costs. This has prompted many employers to reconsider the kind of health insurance protection they are willing to provide as a benefit to their employees. Workers are being asked to absorb an increased share of health care costs.

As a result, disputes over health care benefits have become the single biggest issue in collective bargaining. I believe that in the recent period somewhere in the neighborhood of three-quarters of these labor disputes have focused on health care benefits as the central concern of both employers and employees. The recent NYNEX strike is but one of these disputes.

The absurdity of New Jersey's uncompensated hospital care program is that it is worsening the very problem it was created to help overcome. Responsible employers are increasingly unwilling to subsidize the medical costs of workers who have not been provided protection by their competitors. More and more of them will be driven by competitive pressures to reduce or discontinue their medical benefits. This will increase the cost of uncompensated care, push insurance rates even higher and set off another round of cutbacks in coverage.

Though it is clear to me that the current financing of our uncompensated hospital care program is both a fiscal failure and a potential deterrent to expansion of the New Jersey economy, I recognize that there is no easy answer to this problem. I am confident, however, that the dialogue this Study Commission has set in motion will point the way and, with the Governor's Commission on Health Care in the lead, such efforts will ultimately result in a workable solution.

If there is any way that my staff and I can be of further assistance, please let me know.

Thank you.

BLUE CROSS AND BLUE SHIELD OF NEW JERSEY
STATEMENT BEFORE THE
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

APRIL 16, 1990

Blue Cross and Blue Shield of New Jersey (BCBSNJ) welcomes the opportunity to testify before the Assembly Health Care Policy Study Commission. It is BCBSNJ's hope that the establishment of this Assembly Study Commission is a step toward our state coming to grips with burgeoning crises in both the health insurance and health care financing system in New Jersey.

BCBSNJ provides health insurance to over 3.3 million New Jerseyans. For nearly sixty years BCBSNJ has been the dominant force in health insurance in this state. As a corporation we are proud of our record of achievement and look forward to retaining our position as the preeminent health insurer of New Jerseyans into the 21st century. Our accomplishments and tradition of service to the residents of New Jersey speak for themselves.

Yet today the health insurance industry, including BCBSNJ, and the health care system in New Jersey and our nation finds itself at a crossroad. Perhaps never before have the interrelated issues of accessibility, affordability and quality of care been more in the public eye. The issues facing this commission are difficult ones; at times the problems of the system seem intractable, yet at BCBSNJ we believe that there are programs and policies which can be adopted on both a short term and long term basis which can make health insurance and access to health care more available and affordable to New Jerseyans.

In considering the issue of the availability of health care insurance, this commission should be aware that throughout the United States other states are wrestling with the same problems. Several have initiated programs aimed at addressing this issue; it is possible that some of these initiatives could be tailored to fit the needs of New Jersey. In evaluating other states' proposals, however, this commission must recognize two things: 1) the unique nature of the hospital financing system in this state, and 2) the special role that BCBSNJ plays as a health insurer.

Blue Cross and Blue Shield of New Jersey provides a unique service to the residents of New Jersey. It performs a function not provided by any other health insurer in New Jersey. At BCBSNJ any resident of the State of New Jersey can purchase health insurance, at any time, regardless of their health;

no one is ever denied health insurance when they apply to BCBSNJ. Our position of continuous open enrollment is in sharp contrast to the practices of commercial health insurers which market non-group policies to only the most insurable members of the public. Even using this selective approach, several commercial insurers have withdrawn or are contemplating withdrawal from the non-group marketplace entirely.

It is becoming increasingly difficult for BCBSNJ to perform its statutorily defined role as the insurer of last resort for New Jerseyans. Health care costs continue to rise faster than prices generally. In 1989 BCBSNJ health care costs increased at a rate of 23% compared to an estimated 4.8% for all consumer prices.

The cost of health care has skyrocketed for many reasons including: 1) new medical technology, 2) increased hospital costs, 3) increased utilization as the population ages, and 4) rising malpractice costs, leading to the practice of defensive medicine. These factors are driving health care costs up throughout the United States. Exacerbating the problem in New Jersey and contributing directly to the high cost of health insurance is the problem of cost shifting via the existing hospital finance system.

The ultimate impact of reimbursement of uncompensated care and government cost shifting on health insurance premiums can be illustrated by the fact that approximately 30 cents of every $1 of hospital premium BCBSNJ collects pays for the care of someone other than our subscribers. As the following statistical information illustrates, the impact of cost shifting has been devastating to BCBSNJ's customers. It is especially disturbing that the size of these cost shifts has been increasing so rapidly.

Impact to the Hospital Finance System
(In Millions of Dollars)

	1985	1989	1990 (estimate)
Systemwide			
Uncompensated Care:			
Trust Fund	$281.1	$501.7	$ 600.0
Other	-	125.0	130.0
Medicare Shortfall *	-	59.6	378.3
Total	$281.1	$686.3	$1108.3
BCBSNJ Costs			
Uncompensated Care:			
Trust Fund	$ 49.7	$ 88.8	$106.2
Other	-	22.1	23.0
Medicare Shortfall	-	132.1	265.3
Total	$ 49.7	$243.0	$394.5

* Excluding Medicare share of uncompensated care shortfall

10X

The New Jersey hospital finance system has achieved the goal of providing access to hospital care for the uninsured in the State of New Jersey. Under the existing system the uninsured have not been denied admission to New Jersey's hospitals, and hospitals have been given a means to finance the cost of the care they provide to the uninsured. Still achievement of this goal has not been accomplished without cost; and that cost has been higher health insurance premiums for all purchasers of health insurance.

At the end of this year the Uncompensated Care Trust Fund will expire. It is highly probable that there will be legislative initiatives to renew or replace the current system for financing uncompensated care. It is our hope that the Legislature, led by this commission will examine the existing methodology and look for ways to improve the system. The cost and availability of health insurance is intrinsically tied to the existing health care system. If improvements are made to that system, health insurers and their customers will benefit from these changes.

This is not the first time that the Legislature has studied the problem of affordability of health insurance. In 1988, as a part of Blue Cross and Blue Shield of New Jersey's restructuring legislation, the Legislature created a Study Commission to study Health Service Corporations (BCBSNJ is the only health service corporation operating in New Jersey). Among other things, that Study Commission was charged with studying the question of how best to provide insurance coverage for high risk individuals. Prior to its expiration the Study Commission issued two reports to the Legislature. BCBSNJ was a member of that Commission and endorses the recommendations it made. The members of this Study Commission might wish to review the finding of this prior study to determine if any of its suggestions might merit further consideration.

The report issued by the Study Commission is quite lengthy. For the purposes of this hearing it may prove useful to consider several of its recommendations which focused on making health insurance coverage more affordable.

The Commission recommended that a high risk health insurance pool be established as a separate entity within the State of New Jersey. Premiums for this high risk pool would be no higher than 150% of the amount charged in the standard insurance market. A subsidy would be established in order to meet the costs of claims in excess of premiums collected.

Creation of this high risk pool would alter BCBSNJ's role as the insurer of last resort, but the Commission believed, and BCBSNJ concurs, that BCBSNJ should be allowed to prospectively place a certain number of high risk individuals into such a pool.

Since the enactment of legislation creating the existing hospital rate setting system, BCBSNJ has seen the evaporation of any competitive price advantage it once enjoyed over its commercial competitors. Prior to the rate setting law taking effect Blue Cross enjoyed what amounted to a 25% discount over commercial carriers. This discount was achieved by negotiating agressively with providers. Due to this large discount BCBSNJ was able to hold down the cost of coverage for its individual non-group subscribers, since the discount was used to subsidize premium costs for individuals.

The Blue Cross/Blue Shield Study Commission recognized that under the current hospital rate setting system BCBSNJ could no longer maintain its position as the insurer of last resort. It is for this reason that it recommended the creation of a risk pool. It should be noted that several states have already enacted legislation establishing risk pools.

As you are no doubt aware, the Appellate Division of the Superior Court of New Jersey recently determined that BCBSNJ could not utilize demographic rating in setting its premium rates for its non-group subscribers. The Court ordered the Department of Insurance to expeditiously review the rate increase filed by BCBSNJ on November 14, 1989. In response to this decision, BCBSNJ filed for a revised rate increase with the Department of Insurance. That increase is currently under review.

BCBSNJ is concerned about the impact of the Court's decision on our ability to continue to provide health insurance coverage to direct pay customers. Under the terms of the Court decision, BCBSNJ must revert to community rating for its direct pay customers. Under community rating one rate is charged to all customers who retain the same coverage. Demographic rating, which is used by commercial insurers, recognizes that certain factors (age, sex and location of residence) determine how often individuals utilize benefits. BCBSNJ is very concerned that better risk individuals enrolled in our non-group book of business will be targeted by commercial insurers who through demographic rating will be able to offer them coverage at rates substantially lower than those provided under community rated coverage.

As better risk individuals leave the community group the problem of adverse selection results. Under adverse selection premium increases cause the lowest utilizers of benefits to leave the insurer's pool; either to purchase other insurance, or to go without insurance. When these individuals leave, premiums collected decrease disproportionately to the amount of claims generated by those remaining. As a consequence, larger and more frequent rate increases become necessary. As new higher rates are needed the next lowest group of utilizers opts out of the community pool, and the cycle begins again. The report issued by the Blue Cross/Blue Shield Study Commission recommended

that BCBSNJ be allowed to employ demographic rating for its non-group customers. Based on the Court's decision this is no longer possible. The actual impact of this decision is something which concerns BCBSNJ greatly, since it will probably make it even more difficult for us to provide non-group insurance to all.

This testimony has focused primarily on the problem of providing affordable health insurance to individuals who do not receive health insurance as a condition of their employment. Studies have shown that most of the approximately 800,000 New Jerseyans are, in fact, employed or are the dependents of an employed person. BCBSNJ recognizes that the cost of health insurance is a significant burden on many employers, especially those who operate small businesses. It is certain that if group insurance was more affordable then at least a portion of the state's uninsured population would have coverage provided to them by their employers.

BCBSNJ believes that there are programs which can be undertaken which would reduce the cost of health insurance for employers, especially small employers. If this can be accomplished more employers are apt to voluntarily provide insurance to their employees. As the number of uninsured declines, the pressures on the state's hospital financing system should also decline.

Some of the programs which this Commission might wish to explore further could well require the use of scarce state revenues. BCBSNJ is well aware of the fiscal situation which confronts our state in 1990. Money may not be available at present to institute these programs, but that does not mean that the possibility of instituting these changes is not worth exploring further; when these fiscally difficult times pass it would be prudent to have fully investigated various proposals designed to contain health care costs.

1. Expanded governmental funding for uncompensated care. Ultimately general revenues are a fairer more equitable way to fund this program. While state monies may never be able to fund this program fully, consideration should certainly be given to expanding the Medicaid program. Expansion of Medicaid would bring in additional Federal dollars and increase the number of people who have access to health care.

2. Creation of a risk pool for high risk individuals. For the reasons outlined it is becoming increasingly difficult for BCBSNJ to perform its task as the insurer of last resort in New Jersey. If a risk pool cannot be established then consideration must be given to instituting some form of broad based subsidy for those individuals who must purchase their own health insurance.

3. Programs to encourage small businesses to provide their employees with health insurance benefits. Oregon recently enacted legislation which provides tax credits to small businesses which provide health insurance coverage to their employees. Increasing the number of individuals who receive insurance through the workplace will ultimately have a positive impact on the premiums of all employers.

The above referenced suggestions would require that legislation be enacted before these programs could take effect. Significant public policy questions would need to be addressed to assure that the most appropriate and equitable programs were put into place. Before instituting these suggestions significant research needs to be done.

As an immediate step BCBSNJ would make one suggestion to this Commission and the entire New Jersey Legislature. While all parties strive to achieve a program designed to contain health care costs, no action should be taken on any legislation which would mandate benefits for health insurance policies. When the Legislature intervenes and requires health insurance to provide coverage for specific providers or services it increases the cost of health insurance. Recently the States of Washington and Virginia have enacted legislation waiving the imposition of mandated health insurance benefits on small group health insurance contracts. BCBSNJ believes a proposal of this type would have merit in New Jersey; today, however, we only recommend that the Legislature defer from enacting new mandated benefit legislation.

It is certain that health care will be one of the dominant public policy questions here in New Jersey and throughout the United States in the 1990's. The controversy generated from the recently released Pepper Commission report shows that the issue will continue to be debated in Washington. Governor Florio has taken the lead by stating that one of the major public policy goals of his administration will be to address the health care system in our state. The establishment of this Commission clearly shows that the Assembly intends to be an active partner in finding solutions to the problems at hand.

Blue Cross and Blue Shield of New Jersey is ready to work with our elected leaders in state government and other interested parties to develop programs designed to make health insurance more accessible and affordable for New Jerseyans. BCBSNJ sells heath insurance to employers, labor unions, and individuals in this state. Our past success has been due to our ability to provide New Jerseyans with quality health insurance coverage. Working in conjunction with this Commission and similarly concerned groups BCBSNJ looks forward to the challenges and opportunities that lie ahead.

Statement before
The Assembly Health Care Policy Study Commission
to Examine Access to Health Care in New Jersey
Presented by
James E. Cunningham, President
New Jersey Association of Health Care Facilities

Monday April 16, 1990
Woodbridge Public Library
Woodbridge, New Jersey

We appreciate the opportunity to appear before you this morning and look forward to working with this Commission to examine health care issues which affect New Jersey citizens.

Please let me commend you on the timing of this public hearing. Last week an in-depth New York Times series--reflecting the heightened interest in the subject among a variety of important media outlets--reported on the exponential growth of the elderly ill, their health care options and the problems they face in paying for long-term care. As frequently reported, nursing home care averages $30,000 a year and--too often--drains the life savings of a patient and of his or her immediate family.

Private insurers have developed policies designed to cover the cost of this care and relieve families from the humiliating experience of "spending down" to poverty. Unfortunately, many policies sold today likely will be of little benefit when it's time to draw from them. Typically, these policies neglect to project accurately the future costs of care.

We urge you to create a process to review policies which cover long-term care. It is critical that consumers be assured that the policy they purchase today will truly offset the costs of long-term care many years in the future.

As a guideline, you may want to borrow from New Jersey's Long-Term Care Insurance Program, a pilot project to be undertaken by the Robert Wood Johnson Foundation. The program, slated to begin this year, is designed to devise a plan to protect families from "spending down" in order to pay for skilled and custodial care either at home, in an adult day care center or nursing home. It also includes an annual inflation factor which would ensure that a policy covers the future cost of care. Before this program can begin, the Legislature must approve a measure to indemnify the project.

As you know, Congress also is examining the issue of long-term care insurance. Another action you could initiate would be to introduce a joint resolution memorializing Congress to resolve this issue.

Now, I'd like to address your overall theme of access to health care in New Jersey. Frankly, access to long-term care in this state is in great jeopardy. We call on you today to assist the most medically needy of this state and ensure their right to receive quality nursing home care.

In January, each of you received a copy of a Petition for Rule Making which was submitted to the Department of Human Services from our Association as well as the New Jersey Association of Non-Profit Homes for the Aging. The petition draws on a 1989 study by the Departments of Health and Human Services and shows that more than 80 percent of New Jersey's Medicaid providers in 1988 were not fully reimbursed for actual nursing costs. Facilities suffered total losses of $95.1 million in nursing costs alone. This means that, on the average, each medicaid nursing home in one year lost $500,000 on Medicaid patient care.

An independent study prepared for the two associations revealed losses even more devastating. In that report, 233 of the 261 facilities surveyed--nearly 90 percent--had allowable costs in excess of their Medicaid rates. The aggregate Medicaid loss according to that study was $135.9 million in 1988 - or $2.6 million a week.

This inadequate payment violates a provision of the federal Medicaid statute, commonly known as the "Boren Amendment." That law requires states to establish payment rates which are adequate to reimburse the costs which must be incurred by efficiently and economically operated long-term care facilities. It also prohibits states from using budgetary constraints as a basis for non-compliance with the law. Even though New Jersey's inadequate reimbursement appears to be tied to the State's fiscal woes, we nevertheless are in violation of federal law.

Not only has the Department of Human Services not resolved the issue, it told the industry that a formal review and response to their own data would not be available until September 1990. Both associations view this answer as irresponsible and one which shows a total disregard for federal law.

You can well imagine the human consequences of inadequate Medicaid reimbursement; and I'll add to that in a minute. But non-compliance also threatens the loss of $334 million in federal Medicaid funds for New Jersey. Medicaid is one of the few social programs which is matched dollar-for-dollar by the federal government, and continued non-compliance could force federal funds to be revoked, deepening the State's already grim fiscal picture.

I promised to tell you the human consequences of this inadequate Medicaid reimbursement problem. Speaker Doria said it best when he introduced A-3271, which seeks to permanently correct the Medicaid inequity. He noted that the continued underfunding "can only bring about three equally devastating results:

1) Long-term care facilities will be forced into insolvency, leaving the welfare of countless numbers of sick elderly at risk;

2) Those residents with sufficient resources will be asked to bear even a greater share of un-reimbursed costs, which needlessly would force many onto the Medicaid rolls; and/or

3) The quality of patient care will diminish."

Senator Francis McManimon of Mercer has introduced S-2491 which, like Speaker Doria's bill, would assure that at least 80 percent of medicaid facilities statewide are reimbursed for actual nursing costs. The bills also would adjust the reimbursement methodology to make certain that at least 50 percent of all Medicaid facilities are paid their total allowable non-nursing costs.

The $17.7 million appropriation will be matched dollar-for-dollar with federal funds.

Frankly, we're disappointed that the Governor's proposed tax package does not address this serious Medicaid shortfall. We would propose that each member of this Commission sign on to A-3271 with Mr. Doria and Assemblywoman Ann Mullen of Camden to insure that the most helpless component of our population--the elderly Medicaid nursing home patients--continue to receive the quality of care they require and deserve.

We also would remind you of the serious nursing shortage and the threat it poses to accessing medical care. Without these professionals, units in nursing homes and hospitals will either remain unopened or, even worse, close. We urge you to examine the final recommendations by the Nursing Shortage Study Commission which were released last June. They include:

1) approval of an across-the-board Medicaid increase;

2) control and regulation of nursing personnel pools;

3) a temporary test waiver for foreign-trained nurses;

4) expansion of the use and duties of licensed practical nurses; and

5) a state tax credit or a free tuition program for nursing students who commit to practice their profession in New Jersey for a specified number of years.

Again, the New Jersey Association of Health Care Facilities stands ready to assist this Committee. I'd be happy to answer any questions you have at this time.

# # #

NEW JERSEY HEALTH CARE COALITION

46 Paterson Street, New Brunswick, NJ 08901
(201) 246-4772

STATEMENT OF AL EVANOFF

CO-CHAIR OF THE NEW JERSEY HEALTH CARE COALITION

BEFORE THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

APRIL 16, 1990

CHAIRMAN McGREEVEY AND MEMBERS OF THE COMMISSION:

The New Jersey Health Care Coalition consists of Unions, Senior Organizations, Children and Disabled Organizations, and persons interested in Accessible, Affordable, High Quality Health Care. On behalf of this Coalition, I want to thank you for the opportunity to appear before you today and present our views on some important Health Care matters for New Jersey.

When we discuss the question of accessibility to Health Coverage, we have to bear some facts in mind, and I don't mean the statistic of 37,000,000 Americans being uninsured.

Last week the Census Bureau issued a report that 13% of all Americans are without health insurance, that is 31.5 million people. The startling part of the report is that in the age bracket of 16 to 24 years of age there are 21.9% lacking coverage and 16.2% of those 25 to 34 years of age are uninsured.

Further, the report noted that 26.5% of the Hispanic Americans lacked coverage in 1989. The percentage of Afro-Americans lacking coverage was 20.2 %. This compares with 11.7% of white Americans who were uninsured.

Just prior to this Census report, the Pepper Commission or U.S. Bipartisan Commission on Comprehensive Health Care estimated that in addition to the Americans who lacked coverage, there were as many as 20 million who had inadaquate health coverage.

Couple this with two other factors and we have a major disaster

in the making. The first is the fact that the New Jersey Uncompensated Trust Fund is reaching the 600 million dollar mark. [illegible] is that A. Foster Higgins & Co. of Princeton, which monitors employer health care costs, reported that employer costs rose an average 20.4% in 1989, up from $ 2,160 per employee to $ 2,600. The N.J. Health Dept. reports show we have 843,000 people who are uninsured. Of this 59% are working, which means that 497,000 New Jersey residents are employed and have no health insurance. If these people need hospital care in our State, they would most likely register for charity coverage and have their bills paid out of the Uncompensated Trust Fund. Just as in the nation, we have 24.8% or 209,000 of our 18 to 24 year olders that are not covered We have 27% or 227,000 children and those under 18 years old who are not covered.

With so many people throughout the world looking to us to demonstrate that democracy works, we have the responsibility to go beyond having commissions and issuing reports. We need some laws that will show we care about our children and really know how to live together by finally beginning to put an end to rasicm and other bigotry.

When we speak of access to Health Care, too often we quote the statistic of 37 million Americans lacking Health Insurance. The problem goes far beyond, the question of what uninsured persons do when theyget sick. In N.J., we have our uncompensated trust fund which covers the uninsured and pays their hospital bill. That fund is now about 600 million dollars annually, and still going up. The truth is that the uninsured person by the nature of our system is forced to delay care until he or she is faced with an emergency and ends up in the emergency room of the closest hospital and possibly is admitted. The cost of this procedure is the most costly way to administer care and is a factor in increasing health care costs. Beside the cost the affect on the patient

is also destructive. A visit to a doctor earlier may prevent, through medication or other treatment, the need for emergency room and hospital admission. ~~So we have cost and the danger to the patient.~~ Add to this the fact that under uncompensated care, the third party payers have to share the cost of the uninsured persons care, resulting in increased cost and eventually increased premiums to the consumer. This has a snowball effect, employers faced with increased premiums, cutor cancel their health benefits package adding additional persons on to the list of uninsured.

Our Uncompensated Care program not only has a sunset provision but it is growing at such a fast pace that it requires more than a 20% surcharge on hospital bills. We all pay this bill through higher premiums to insurance providers. There is no question that we need the safty net as provided by the uncompensated fund but there is also a need to cut back on this rising cost. The tax payers of N.J. are subsidizing those employers who do not provide health care coverage to their employees, by shifting the cost of the employees health care onto the uncompensated fund. It seems unlikely that the Federal Government will enact the Kennedy-Waxman bill mandating all employers to provide health care coverage. New Jersey should become the third state to enact legislation to require employers to carry basic health insurance for all its employees.

The argument against this legislation is that it will force small employers out of business or that this extra cost will prevent some businesses from competing on the world market. These are the same arguments that have been made over the years against improving the minimum wage, against workers compensation and unemployment insurance. The organizations that make these arguments seem to return

again and again to hold up progress in America, but examination shows that the small companies continue to grow and prosper. These statements make for good propaganda, but are not the facts.

In New Jersey we have about 158,000 firms that can be considered small businesses, that is fewer than 21 employees. If, in any law passed, we eliminated for the present any employer of three or less, we would eliminate 55% of the small firms. If we mandate coverage in cases where a employer has four employees we are not talking of small Mamma and Pappa operations. When we talk of competing on the International market, we have to understand that the larger companies provide their employee with some form of health coverage at present. Health may be a serious cost item but the larger companies in the main do not add to the uninsured. It is in the service industries that we find the greatest number of employees with no coverage. In these cases, general ~~money~~ public is subsidizing the employer who provides no coverage.

We cannot wait for the Federal Government to enact legislation. Each day that goes by, additional persons are being added to the list of uninsured. In those cases where employers are bound by union contracts, the cost of health care is complicating labor negotiations and causing a disruption in peaceful collective bargaining.

Any law we adopt should provide that those persons that will not receive health coverage because they are not employed should be covered by a Uncompensated Trust Fund or we should establish a Health Fund similar to the unemployment fund to provide for the unemployed and other uninsured.

When we speak of access we also have the obligation to examine two areas where we supposedly have access to health care but the administration of these programs leaves a great deal to be desired. The poor have coverage for health care under the Medicaid Program but we provide such low reimbursement for medical providers that the poor are deprived of medical

care because of lack of doctors in their communities and have to resort to emergency room care in case of illness. Although everyone denies double standards, we actually practice a secondary level of care for the poor. This must be corrected and in the long run will save money because Emergency Room treatment is the most expensive way of providing health care. To correct this situation we have to upgrade the medicaid reimbursement to the medicare level and encourage doctors to practice in the poor communities of the State.

The second area is the care provided the elderly and disabled. We have coverage, under the Medicare Program, but the system requires greater and greater out-of-pocket costs so as to cause the system to break down. When a doctor is not ready to accept the Medicare fee or to take assignment, and 72% fall into this category, the senior or disabled is then compelled to pay out-of-pocket costs, in New Jersey those costs amounted to over one hundred million dollars in 1989. The requirement of large out-of-pocket costs is forcing seniors and disabled to avoid going to doctors until the illness requires an emergency room visit and this multiplies the cost of health care. It also impacts on the uncompensated Trust Fund since we no longer enjoy a medicare waver.

This injustice to the elderly and disabled can be corrected by passage of Medicare Assignment Legislation before the Assembly as A-3042 introduced by Assembly persons Stephanie R. Bush and James McGreevey and S-1975 before the Senate introduced by Senator Carmen Orechio.

It would be to the credit of this Commission to call on our Congressional Delegation to work for the establishment of a National Health Program of Comprehensive Health Care for all Americans. Lacking a National effort it would be proper to have a New Jersey Health Task Force to develop a New Jersey State Health Care Program providing health care to every resident. In this way we can reverse the trend in Health Care of watching

cut for the bottom dollar and place the emphasis on providing quality health care for everyone who needs it.

27X

NJANPHA
Founded 1931

New Jersey Association of Non-Profit Homes for the Aging

760 Alexander Road, CN-1, Princeton, New Jersey 08543-0001 (609) 452-1161

Apartments for Independent Living
Continuing Care Retirement Communities
County Nursing Homes
Homes for the Aging

Len Fishman
Cohen, Shapiro, Polisher, Shiekman & Cohen
General Counsel

Lois E. Forrest
Chairperson
Karen J. Uebele
President

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

TESTIMONY ON BEHALF OF
THE NEW JERSEY ASSOCIATION OF NON-PROFIT HOMES FOR THE AGING

The New Jersey Association of Non-Profit Homes For the Aging is committed to providing quality health care on behalf of all New Jersey residents and supports access to health care for one and all. In 1985 NJANPHA supported legislation which required long term care facilities (LTCF's) to accept their fair share of medicaid patients. The problem has not been the willingness of long term care facilities to provide access to health care, but the failure of medicaid to provide reasonable reimbursement for the care of these patients.

Over the past decade, the gap between Medicaid reimbursement and facilities' actual costs for their Medicaid patients has reached unprecedented and critical proportions. What had been a steady erosion in Medicaid reimbursement became a landslide in recent years because of soaring labor costs for nursing personnel. This reimbursement shortfall is forcing providers to choose between reducing access to Medicaid patients or cutting costs that will reduce the quality of care. Instead, Medicaid reimbursement must be restored to levels that assure full reimbursement to a majority of Medicaid providers.

As noted in a 1989 study by the Department of Human Services and the Department of Health, 81.5% of LTCF's were found to have nursing costs in 1988 which exceeded Medicaid's payment rates. The study also showed that LTCF's sustained total Medicaid losses on nursing costs alone of $95.1 million in 1988. An additional independent study prepared by Hubco Health Care Group found that 89.3% of participating Medicaid facilities had allowable costs in excess of their rates, with losses totalling $135.9 million.

On January 11, 1990 the New Jersey Association of Non-Profit Homes for the Aging (NJANPHA) in conjunction with the New Jersey Association of Health Care Facilities (NJAHCF) filed a Petition for Rulemaking with the New Jersey Department of Human Services to obtain adjustments to the Medicaid rates for long term facilities. Coinciding with this petition was the filing of legislation (S-2491) and (A-3271) which would: assure that 80% of the Medicaid facilities statewide are reimbursed for their actual allowable nursing costs; adjust the reimbursement methodology for operating costs other than nursing to assure that 50% of all Medicaid facilities are paid for total allowable costs, and increase the wage equalization factor for those providers within the low salary region.

The estimated annual cost of the bill is $70,688,000, of which 50% ($35,344,000) would be paid by the State and 50% by the Federal Government. The bill would be retroactive to January 1, 1990. Accordingly, it appropriates $17,672,000 in State funds and an equal amount in Federal funds for the period January 1 through June 30, 1990 (that is, one half of FY 1990).

New Jersey is required under the Federal Medicaid statute commonly referred to as the "Boren Amendment", to establish Medicaid payment rates that are adequate to reimburse the costs which must be incurred by efficiently and economically operated facilities. New Jersey's rate setting methodology fails to meet this standard given the extremely small number of facilities that receive rates which cover their actual costs.

Our Association encourages and supports all efforts to provide quality health care at affordable rates for New Jersey's residents. NJANPHA will continue to pursue and support alternative programs and resources which would provide health care coverage for all, helping to alleviate the social dilemma of unavailable health care due to lack of financial resources.

APRIL 16, 1990

Affiliated with
AAHA
AMERICAN ASSOCIATION OF
HOMES FOR THE AGING

28X

ASSEMBLY, No. 3271

STATE OF NEW JERSEY

INTRODUCED MARCH 22, 1990

By Assemblyman DORIA and Assemblywoman Mullen

AN ACT concerning Medicaid reimbursement to skilled nursing and intermediate care facilities, amending P.L.1968, c.413 and making an appropriation therefor.

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

1. Section 7 of P.L. 1968, c.413 (C.30:4D-7) is amended to read as follows:

7. Duties of commissioner. The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum federal participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

a. Subject to the limits imposed by this act, to submit a plan for medical assistance, as required by Title XIX of the federal Social Security Act, to the federal Department of Health and Human Services for approval pursuant to the provisions of such law; to act for the State in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the State the benefits of the provisions of such law;

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the department shall provide medical assistance on behalf of all recipients of categorical assistance and such other related groups as are mandatory under federal laws and rules and regulations, as they now are or as they may be hereafter amended, in order to obtain

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

Matter underlined thus is new matter.

29X

federal matching funds for such purposes and, in addition, provide medical assistance for the foster children specified in section 3i. (7) of this act. The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished such groups, and in addition, shall include at least the minimum services required under federal laws and rules and regulations to obtain federal matching funds for such purposes.

The commissioner is authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and foster children authorized pursuant to section 3i. (7) of this act, so as to include, in whole or in part, the optional medical services authorized under federal laws and rules and regulations, and the commissioner shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain federal matching funds.

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to issue, or cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules, regulations and administrative orders, and to do or cause to be done all other acts and things necessary to implement and administer demonstration projects pursuant to Title XI, section 1115 of the federal Social Security Act, including, but not limited to waiving compliance with specific provisions of this act, to the extent and for the period of time the commissioner deems necessary, as well as contracting with any legal entity, including but not limited to corporations organized pursuant to Title 14A, New Jersey Statutes (N.J.S.14A:1-1 et seq.), Title 15, Revised Statutes (R.S.15:1-1 et seq.) and Title 15A, New Jersey Statutes (N.J.S.15A:1-1 et seq.) as well as boards, groups, agencies, persons and other public or private entities;

c. To administer the provisions of this act;

d. To make reports to the federal Department of Health and Human Services as from time to time may be required by such federal department and to the New Jersey Legislature as hereinafter provided;

e. To assure that any applicant, qualified applicant or recipient shall be afforded the opportunity for a hearing should his claim for medical assistance be denied, reduced, terminated or not acted upon within a reasonable time;

f. To assure that providers shall be afforded the opportunity for an administrative hearing within a reasonable time on any valid complaint arising out of the claim payment process;

30X

g. To provide safeguards to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of this act;

h. To take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider from such provider or his estate or from any other person, firm, corporation, partnership or entity responsible for or receiving the benefit or possession of the incorrect or illegal payments or their estates, successors or assigns, and to assess and collect such penalties as are provided for herein;

i. To take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient, including those made after a voluntary divestiture of real or personal property or any interest or estate in property for less than adequate consideration made for the purpose of qualifying for assistance. The division shall take action to recover the cost of benefits from a recipient, legally responsible relative, representative payee, or any other party or parties whose action or inaction resulted in the incorrect or illegal payments or who received the benefit of the divestiture, or from their respective estates, as the case may be and to assess and collect the penalties as are provided for herein, except that no lien shall be imposed against property of the recipient prior to his death except in accordance with section 17 of P.L.1968, c.413 (C.30:4D-17). No recovery action shall be initiated more than five years after an incorrect payment has been made to a recipient when the incorrect payment was due solely to an error on the part of the State or any agency, agent or subdivision thereof;

j. To take all necessary action to recover the cost of benefits correctly provided to a recipient from the estate of said recipient in accordance with sections 6 through 12 of this amendatory and supplementary act;

k. To take all reasonable measures to ascertain the legal or equitable liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability; where it is known that a third party has a liability, to treat such liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such a liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such liability;

l. To compromise, waive or settle and execute a release of any claim arising under this act including interest or other penalties, or designate another to compromise, waive or settle and execute a release of any claim arising under this act. The commissioner or his designee whose title shall be specified by regulation may compromise, settle or waive any such claim in whole or in part,

either in the interest of the Medicaid program or for any other reason which the commissioner by regulation shall establish;

m. To pay or credit to a provider any net amount found by final audit as defined by regulation to be owing to the provider. Such payment, if it is not made within 45 days of the final audit, shall include interest on the amount due at the maximum legal rate in effect on the date the payment became due, except that such interest shall not be paid on any obligation for the period preceding September 15, 1976. This subsection shall not apply until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, subpenas to compel the attendance of witnesses and the production of books, records, accounts, papers and documents of any party, whether or not that party is a provider, which directly or indirectly relate to goods or services provided under this act, for the purpose of assisting in any investigation, examination, or inspection, or in any suspension, debarment, disqualification, recovery, or other proceeding arising under this act;

o. To solicit, receive and review bids pursuant to the provisions of P.L.1954, c.48 (C.52:34-6 et seq.) and all amendments and supplements thereto, by any corporation doing business in the State of New Jersey, including nonprofit hospital service corporations, medical service corporations, health service corporations or dental service corporations incorporated in New Jersey and authorized to do business pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), or P.L.1968, c.305 (C.17:48C-1 et seq.), and to make recommendations in connection therewith to the State Medicaid Commission;

p. To contract, or otherwise provide as in this act provided, for the payment of claims in the manner approved by the State Medicaid Commission;

q. Where necessary, to advance funds to the underwriter or fiscal agent to enable such underwriter or fiscal agent, in accordance with terms of its contract, to make payments to providers;

r. To enter into contracts with federal, State, or local governmental agencies, or other appropriate parties, when necessary to carry out the provisions of this act;

s. To assure that the nature and quality of the medical assistance provided for under this act shall be uniform and equitable to all recipients;

t. To provide for the reimbursement of State and county-administered skilled nursing and intermediate care facilities through the use of a governmental peer grouping system, subject to federal approval and the availability of federal reimbursement.

(1) In establishing a governmental peer grouping system, the

32X

State's financial participation is limited to an amount equal to the nonfederal share of the reimbursement which would be due each facility if the governmental peer grouping system was not established, and each county's financial participation in this reimbursement system is equal to the nonfederal share of the increase in reimbursement for its facility or facilities which results from the establishment of the governmental peer grouping system.

(2) On or before December 1 of each year, the commissioner shall estimate and certify to the Director of the Division of Local Government Services in the Department of Community Affairs the amount of increased federal reimbursement a county may receive under the governmental peer grouping system. On or before December 15 of each year, the Director of the Division of Local Government Services shall certify the increased federal reimbursement to the chief financial officer of each county. If the amount of increased federal reimbursement to a county exceeds or is less than the amount certified, the certification for the next year shall account for the actual amount of federal reimbursement that the county received during the prior calendar year.

(3) The governing body of each county entitled to receive increased federal reimbursement under the provisions of this amendatory act shall, by March 31 of each year, submit a report to the commissioner on the intended use of the savings in county expenditures which result from the increased federal reimbursement. The governing body of each county, with the advice of agencies providing social and health related services, shall use not less than 10% and no more than 50% of the savings in county expenditures which result from the increased federal reimbursement for community-based social and health related programs for elderly and disabled persons who may otherwise require nursing home care. This percentage shall be negotiated annually between the governing body and the commissioner and shall take into account a county's social, demographic and fiscal conditions, a county's social and health related expenditures and needs, and estimates of federal revenues to support county operations in the upcoming year, particularly in the areas of social and health related services.

(4) The commissioner, subject to approval by law, may terminate the governmental peer grouping system if federal reimbursement is significantly reduced or if the Medicaid program is significantly altered or changed by the federal government subsequent to the enactment of this amendatory act. The commissioner, prior to terminating the governmental peer grouping system, shall submit to the Legislature and to the governing body of each county a report as to the reasons for terminating the governmental peer grouping system;

u. The commissioner, in consultation with the Commissioner of

33X

Health, shall:

(1) Develop criteria and standards for comprehensive maternity or pediatric care providers and determine whether a provider who requests to become a comprehensive maternity or pediatric care provider meets the department's criteria and standards;

(2) Develop a program of comprehensive maternity care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) Develop a program of comprehensive pediatric care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L. 1968, c. 413 (C. 30:4D-1 et seq.);

(4) Develop and implement a system for monitoring the quality and delivery of comprehensive maternity and pediatric care services and a system for evaluating the effectiveness of the services programs in meeting their objectives;

(5) Establish provider reimbursement rates for the comprehensive maternity and pediatric care services;

v. The commissioner, jointly with the Commissioner of Health, shall report to the Governor and the Legislature no later than two years following the date of enactment of P.L. 1987, c. 115 (C. 30:4D-2.1 et al.) and annually thereafter on the status of the comprehensive maternity and pediatric care services and their effectiveness in meeting the objectives set forth in section 1 of P.L. 1987, c. 115 (C. 30:4D-2.1) accompanying the report with any recommendations for changes in the law governing the services that the commissioners deem necessary;

w. The commissioner shall calculate and pay, or cause an underwriter, fiscal intermediary or fiscal agent with which the commissioner has contracted pursuant to this act to calculate and pay, per diem reimbursement rates for skilled nursing facilities and intermediate care facilities approved as Medicaid providers. The reimbursement rates shall be calculated so that (1) at least 80% of the skilled nursing facilities and intermediate care facilities are reimbursed for their total costs of nursing personnel, including, but not limited to, the total costs for directors of nursing, contracted nursing services, registered professional nurses, licensed practical nurses and nurse aides, and (2) at least 50% of the skilled nursing facilities and intermediate care facilities are reimbursed for the total of all their other costs. The commissioner may increase the reimbursement rate of a facility by a factor to compensate for the effects of geographic cost differentials but shall not reduce the reimbursement rate of a facility because of these differentials.

(cf: P.L.1988, c.6, s.1)

34X

2. There is appropriated $17,672,000 from the General Fund and $17,672,000 in federal funds to the Department of Human Services to carry out the provisions of this act.

3. This act shall take effect immediately and shall be retroactive to January 1, 1990.

STATEMENT

New Jersey's long-term care facilities confront a crisis in Medicaid reimbursement. Over the past decade, the variance between facilities' actual costs of caring for their Medicaid patients and reimbursement from the Medicaid program has reached an unprecedented and critical level. This reimbursement shortfall is forcing providers to choose between reducing access to Medicaid patients or cutting costs that would reduce the quality of care.

P.L.1989, c.18 required the Commissioners of Health and Human Services to analyze Medicaid reimbursement to long-term care facilities in the area of nursing costs, the single largest category of expense for such facilities. The results of their analysis were contained in a report to the Legislature issued in September 1989. The report found that only 19% of long-term care facilities are fully reimbursed for their nursing costs by the Medicaid program. This means that Medicaid's reimbursement limit is now so low that eight out of 10 long-term care facilities are forced to spend more on nursing (for registered nurses, licensed practical nurses and nurses aides), than they receive in reimbursement from the Medicaid program.

The need for adequate reimbursement to attract and retain patient care personnel has been recognized consistently in New Jersey's hospitals through increases in reimbursement granted by the Hospital Rate Setting Commission. In addition, the State has increased salaries for its own patient care personnel and has provided bonuses to nurses it employs in the State institutions. Private and governmental long-term care facilities, however, have not received comparable relief.

This bill appropriates $17,672,000 in State funds and $17,672,000 in federal matching funds to enable the Medicaid program to pay adequate costs of reimbursement to private and governmental long-term care facilities in New Jersey. Specifically, the bill requires the Commissioner of Human Services to adjust the Medicaid rate setting methodology to assure that no less than 80% of participating Medicaid providers are reimbursed for total costs for all nursing personnel. The bill would also require the commissioner to adjust the Medicaid rate setting methodology to assure that no less than 50% of participating Medicaid providers are reimbursed their total costs for all other cost areas. Finally, the bill would provide relief to

35X

facilities located in the current designated "low" salary regions around the State. The bill would prohibit the commissioner from reducing reimbursement to facilities on the basis of geographic location; however, the commissioner would still be permitted to provide increased reimbursement to facilities based on geographic location. Accordingly, the commissioner may use geographic location as a factor in calculating a facility's reimbursement, but the geographic factor (commonly referred to as an "equalization factor") for any given facility or group of facilties could not be less than the Statewide equalization factor.

HUMAN SERVICES

Increases reimbursement to Medicaid long-term care facilities.

36 X

USA UNITED SENIOR ALLIANCE

P.O. Box 8866, Trenton, New Jersey 08650

Phone: (609) 443-4667

T E S T I M O N Y

BEFORE THE

ASSEMBLY HEALTH CARE POLICY COMMISSION

April 16, 1990

JOSEPH F. RIORDAN

PRESIDENT - UNITED SENIOR ALLIANCE

STATE COORDINATOR - THE LONG TERM CARE CAMPAIGN

VOICE OF THE ELDERLY
UNITED SENIOR ALLIANCE

37X

Equality, Decency and Justice For All Seniors

GOOD MORNING. THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE.

EVERY CITIZEN OF THE UNITED STATES IS ENTITLED TO ADEQUATE HEALTH CARE. SO IT FOLLOWS THAT EVERY RESIDENT OF THE STATE OF NEW JERSEY SHOULD HAVE ACCESS TO THE HEALTH CARE SYSTEM. THE REALITY IS THAT MORE THAN 15% OF ALL AMERICANS DO NOT HAVE DIRECT ACCESS TO DOCTOR OR HOSPITAL SERVICES BECAUSE THEY DO NOT HAVE HEALTH INSURANCE. THE PERCENTAGE OF UNINSURED IN NEW JERSEY IS SLIGHTLY LOWER. IT IS SAID THAT THE FIRST QUESTION ASKED AT THE HOSPITAL ADMISSIONS DESK, OR THE EMERGENCY ROOM, IS "WHAT INSURANCE COVERAGE DO YOU HAVE?" THE COMMON SIGN IN THE DOCTOR'S OFFICE IS "PAYMENT IS EXPECTED FOR SERVICES PROVIDED." THESE CIRCUMSTANCES CAUSE THE UNINSURED TO FOREGO NEEDED MEDICAL ATTENTION UNTIL THE SITUATION BECOMES MORE SERIOUS WITH RESULTANT NEED FOR EXPENSIVE HIGH-TECH PROCEDURES. THESE ARE THE KIND OF SITUATIONS WHICH MAKE COST CONTAINMENT MORE DIFFICULT.

WHO ARE THE UNINSURED? ABOUT 60% ARE EMPLOYED OR UNDER-EMPLOYED IN JOB SITUATIONS WHERE THEIR EMPLOYERS PROVIDE NO HEALTH INSURANCE. MANY OF THEM ARE SINGLE PARENTS. THEY CERTAINLY CANNOT AFFORD THE $3000 or $4000 PER YEAR IT WOULD COST TO PURCHASE A MODERATE HEALTH CARE POLICY.

WHAT HAPPENS IN OUR STATE WHEN THE UNINSURED BECOME ACUTE CARE HEALTH SITUATIONS? THEY ARE NOT SHUNTED ASIDE. THEY RECEIVE THE SAME QUALITY OF CARE AS ANY OTHER HOSPITAL PATIENT AND THE HOSPITAL IS REIMBURSED. THE MEANS USED IS THE UNCOMPENSATED CARE TRUST FUND, WHICH MORE APTLY COULD BE CALLED THE UNINSURED CARE FUND. THE UNCOMPENSATED CARE TRUST FUND IS GENERATED BY ASSESSING AN ADDITIONAL AMOUNT TO EACH PAYING PATIENT'S BILL.

BECAUSE MOST OF THESE PATIENTS ARE COVERED BY INSURANCE THROUGH AN EMPLOYER OR BENEFIT FUND, THESE ADDED COSTS TRICKLE DOWN TO BECOME ADDED PREMIUM COSTS. THIS, IN MY OPINION, IS SIMPLY UNJUST AND UNFAIR. WHY SHOULD AN EMPLOYER OR BENEFIT FUND THAT PROVIDES INSURANCE HAVE TO PAY ADDITIONAL PREMIUM COSTS TO COVER AN EMPLOYEE WHOSE EMPLOYER DOES NOT PROVIDE INSURANCE.

TO COVER THIS PORTION OF THOSE WHO DO NOT HAVE ACCESS THERE WILL HAVE TO BE A REQUIREMENT THAT ALL EMPLOYED PEOPLE HAVE HEALTH INSURANCE THROUGH THEIR EMPLOYERS. THIS INSURANCE COULD BE THROUGH A PRIVATE INSURER OR PERHAPS A STATE PLAN. IN EITHER CASE, THERE WOULD HAVE TO BE SOME SPECIFIC REGULATIONS ENSURING AVAILABLE COVERAGE FOR PRE-EXISTING CONDITIONS, AND POSITIVE ACCESS BY ALL GROUPS REQUESTING COVERAGE. IT WOULD BE ESSENTIAL THAT THESE POLICIES BE DEVELOPED TO ADDRESS COST CONTAINMENT, QUALITY ASSURANCE AND EFFICIENT ADMINISTRATION. A FORM OF COST SHARING COULD BE CONSIDERED IN THE PROGRAM. THOSE EMPLOYERS WHO DO NOT PROVIDE INSURANCE WOULD BE REQUIRED TO CONTRIBUTE TO A STATE PLAN WHICH WOULD BE ESTABLISHED. THIS PACKAGE WOULD PROVIDE COVERAGE FOR ALL EMPLOYEES AND THEIR DEPENDENTS.

REMAINING WOULD BE A GROUP ESTIMATED TO BE ABOUT 350,000 PEOPLE INCLUDING A FAIR PERCENTAGE OF CHILDREN. THE REAL MAKE-UP OF THIS GROUP WOULD PROBABLY HAVE TO BE DETERMINED BY AN ANALYSIS OF UNCOMPENSATED CARE FUND PARTICIPANTS.

SINCE NEW JERSEY HAS ALWAYS BEEN IN THE FOREFRONT OF INNOVATING HEALTH CARE INITIATIVES, PERHAPS WE SHOULD BE LOOKING AT A SYSTEM WHICH MIGHT BRING ABOUT INCREASED AVAILABILITY OF A MEDICAID-MEDICARE TYPE PROGRAM. THERE IS THE POSSIBILITY OF A DEDICATED FUNDING SOURCE TO BE CONSIDERED.

IN THE FIVE YEARS I HAVE BEEN INVOLVED IN THE SENIOR CITIZEN MOVEMENT, WE HAVE BEEN TRYING TO ADDRESS THE PROBLEMS OF THOSE "WHO FALL BETWEEN THE CRACKS". THESE ARE THE PEOPLE WHO BY REASON OF THEIR INCOME DO NOT QUALIFY FOR MEDICAID OR PAAD, BUT WHO HAVE PRESSING NEED, IN SOME INSTANCES, FOR SOME HEALTH CARE SERVICES. WE CONTINUE TO ADDRESS THESE NEEDS BY THE LONG TERM CARE CAMPAIGN AND VARIOUS SMALL PROGRAMS ON THE STATE LEVEL.

THE SEGMENT OF THE POPULATION WHO DO NOT HAVE DIRECT ACCESS TO THE HEALTH CARE SYSTEM ARE OFTEN PROUD PEOPLE FOR WHOM THE PRESENT PROCESS IS DEMEANING. THEY OFTEN DELAY SEEKING HELP WHICH SOMETIMES RESULTS IN THE NEED FOR EXTENSIVE, EXPENSIVE PROCEDURES. WE MUST DEVELOP AN ACCESS PLAN. NEW JERSEY IS THE PLACE TO START. EVERY HUMAN BEING IS ENTITLED TO DIGNITY, EQUALITY AND JUSTICE IN EVERY PHASE OF THEIR LIVES.

I CLOSE BY SAYING THAT IN THE FIVE YEARS I HAVE BEEN INVOLVED IN THE HEALTH CARE SYSTEM I HAVE SUPPORTED NUMEROUS INITIATIVES. AS I LOOK BACK, I SEE THAT THEY WERE MOSTLY BAND-AIDS. AS A NATION WE SPEND A GREATER PERCENTAGE OF OUR GROSS NATIONAL PRODUCT ON HEALTH CARE THAN ANY OTHER INDUSTRIAL NATION IN THE WORLD. DESPITE THE EXPENDITURE, WE RANK LOW IN MOST AREAS OF HEALTH. IT IS DISTRESSING TO SEE AND HEAR ABOUT THE NEO-NATAL CASES IN OUR HOSPITALS, THE EARLY DEATHS FROM HEART AND BLOOD PRESSURE PROBLEMS IN THE BLACK POPULATION, THE NUMEROUS HEALTH PROBLEMS IN RURAL AREAS AROUND THE COUNTRY AND IN THE INNER CITIES. AS A NATION WE SHOULD BE ASHAMED OF OURSELVES. SOME PARTICIPANTS IN THE SYSTEM GET WEALTHY, BUT MORE DIE BEFORE THEIR TIME.

THE TIME IS APPROACHING WHEN WE WILL STOP APPLYING BAND-AIDS. IN THIS DECADE, IT IS MY BELIEF, A UNIVERSAL HEALTH CARE SYSTEM WILL COME INTO BEING IN THE UNITED STATES. THEN, THE ENTIRE POPULATION WILL HAVE QUALITY HEALTH CARE DURING THEIR NORMAL LIFE SPANS. THERE MAY BE SOME, WHO PERHAPS WITH NO QUALITY OF LIFE, WILL LEAVE US EARLIER. HOWEVER, WE DO BELIEVE THAT THE STATUS OF OUR HEALTH CARE AS A NATION WILL IMPROVE.

THANK YOU.

STATEMENT OF THE

NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION

TO THE

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

April 16, 1990

42X

My name is Maureen Lopes. I am Vice President for Health Affairs at the New Jersey Business & Industry Association. I appreciate this opportunity to share with the Assembly Health Care Policy Study Commission some of the concerns of the business community with regard to health care insurance in New Jersey.

I am sure that you are well aware of the impact which the increase in health care costs is having on businesses across the country. When even the large auto makers are calling for major reforms to the payment system, you can imagine the adverse impact health care costs are having on small and medium size companies which are struggling to maintain health insurance coverage for their employees. The results of a survey done by Foster Higgins of 1989 employer health care benefits recently reported that the average total per-employee health plan cost in New Jersey was $2,827 with the cost of indemnity plans up by 20.4% over 1988. Within this average, costs range from approximately $2,000 for single coverage to $5,000 per year for family coverage. I ask you to consider what it means to a company with 20 employees to pay $2,827 per year per employee for health insurance and to experience 20% annual increases. Health insurance premiums are growing much more rapidly than the other expenses on companies' income statements.

As this Commission proceeds with its public hearings I urge it to bear in mind the changes which have occurred in New Jersey's hospital costs over the past several years. Data from 1986 seemed to indicate that New Jersey's hospital costs were low compared to national averages. However, the sharp rise in health insurance premiums in 1988, 89 and 90 are a reflection of a

catching up by the hospital reimbursement system. The lack of prospectivity in the rate setting system is a major problem for insurers and the payers (business and government).

As I noted earlier, the rapid rise in health insurance premiums is a major concern to even large businesses, especially as they face increased global competition and a slowing of New Jersey's economy. However, NJBIA is particularly concerned about the 80% of its members who employ 50 or fewer employees. I am receiving several telephone calls a week from small companies who are struggling to continue health care coverage for their employees. I am frustrated by the relatively few options which I can suggest to these companies. The deck is stacked against them in the health insurance market by the fact that small firms pay 10-40 percent more for health insurance than larger employers. (1)

Studies show that high premium costs are the reason that 11% of our citizens are without health insurance. Mandated benefits significantly increase those costs. Economists John Goodman and Gerald Musgrave have estimated that one-quarter of the nation's uninsured are uninsured because of mandates. (2) I am a member of the subcommittee of the Uncompensated Care Trust Fund Advisory Board which is seeking ways to make insurance more affordable to small employers. It is clear to me that the cost of mandates are a significant limiting factor to our efforts. In Maryland a state legislative committee concluded that:

> ...mandated coverages passed by the legislature in the last decade may have increased the cost of health care to the health insurance

policyholder without necessarily improving the quality.... The committee questions the ability of the average policy holder to afford these mandated coverages when one considers that there is doubt as to whether his health care has been improved. (3)

Legislative votes on mandate bills are really choices between covering every specialized procedure and professional service at any cost or ensuring that the majority of New Jersey's citizens are covered for basic health services.

A second impediment to small businesses is the federal tax law which raises the cost of health insurance for small businesses. Corporations are allowed to deduct the full cost of premiums as a business expense. However, a sole proprietor may only deduct twenty-five percent of the premium cost. The Employee Benefit Research Institute estimates that nationally the self-employed and their dependents comprise more than 23 percent of the uninsured population. (4)

Small firms also face higher transaction and administrative costs when purchasing health insurance. Affordability is also affected by medical underwriting practices where one or two "bad risks" in a small group can significantly increase premium costs.

45X

RECOMMENDATIONS

1. **Establish a review board to study the economic impact of all current and proposed state mandates** - Several states have already established such boards. The first order of business should be a sound economic analysis of the cost of the services currently mandated by New Jersey. At least one insurer has estimated that mandates add 9% to premium costs in New Jersey but reliable figures must be developed in order to guide public policy.

2. **Reform the current hospital reimbursement system to establish prospective rates, as was intended under the original law which established the DRG system** - The lack of prospectivity in the current system makes a guessing game out the efforts of indemnity companies and HMOs to set annual premiums. Some portion of the current financial problems of Blue Cross/Blue Shield, and the bankruptcy of several HMOs in New Jersey, can be attributed to large, unanticipated, retroactive rate increases to hospitals.

3. **Finance uncompensated care through a broad-based mechanism instead of a surcharge to premiums and patients' bills** - The current surcharge of approximately 22% is a major factor in the cost of health insurance in New Jersey. The withdrawal of Medicare from the Trust Fund at the beginning of 1989 has resulted in a major shift in costs to the employer community. We look forward to reviewing the recommendations from the Governor's Commission on Health Care Costs which will, hopefully, correct the current inequities.

4. **Review the current laws and regulations governing Multiple Employer Trusts (METs)** - METs are group arrangements formed to help small firms obtain health care coverage on a more cost effective basis. Information has not been readily available from the Department of Insurance on how many METs are functioning in New Jersey. Business groups, such as the Southern New Jersey Chamber of Commerce, are attempting to increase the affordability of health insurance for small businesses by offering a group plan. But it is very difficult and time-consuming for employers in other parts of the state to locate group buying arrangements. Is the formation of such arrangements encouraged by current law and regulation?

5. **Allow small businesses to "buy-in" to the Garden State Health Plan** - Managed care health plans will represent close to 100% of the health insurance market by the end of the decade. As the state's public HMO for Medicaid recipients, the Garden State Health Plan already exists to expand the quality and availability of care for New Jersey's poor. Allowing businesses which employ low wage workers to buy into the Plan, on a sliding scale basis, would increase coverage for the working poor. Such coverage is likely to have a positive affect on the Uncompensated Care Trust Fund.

6. **Consider establishing a high risk pool to lower premiums for small groups with a few uninsurable individuals** - Such a pool may be needed to replace the community underwriting formerly done by Blue Cross/Blue Shield. Because all citizens run the risk of falling into the uninsurable category at some point in their lives, a pool should be financed by a broad-based mechanism.

REFERENCES

1. State of Small Business, A Report to the President, 1987.
2. Freedom of Choice in Health Insurance, National Center for Policy Analysis, Dallas, Texas, Nov. 1988.
3. Rx for Health Care, The Partnership on Health Care & Employment, Washington, D.C., December 1989.
4. Uninsured in the United States: The Nonelderly Population Without Health Insurance, Employee Benefits Research Institute, Washington, D.C., 1988.

STATEMENT

OF LEGAL SERVICES OF NEW JERSEY

TO THE

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

April 16, 1990

49x

Leighton Holness, Senior Attorney

Melville D. Miller, Jr.
President

As representatives of poor people, Legal Services of New Jersey welcomes this opportunity to express our concerns about access to health care in New Jersey. We are particularly concerned with the need for Medicaid expansion and with the future of New Jersey's Uncompensated Care Trust Fund, the State's most important program for assuring access to hospital care for poor people.

New Jersey law recognizes the reasonable cost of uncompensated care as an element of cost which must be included in hospital payment rates charged to purchasers of hospital services. The Uncompensated Care Trust Fund now spreads the cost of the uncompensated care evenly across hospitals in the State thereby preventing "patient dumping", always a temptation if each hospital was left to collect through its own rates the fund to pay for its own uncompensated care.

Hospitals must provide uncompensated care largely because many people don't have health insurance. These are usually poor people. Approximately 25 percent of New Jersey residents with a family income below the federal poverty level don't have health insurance. About one fifth of all New Jersey residents without health insurance of any kind have family income below the federal poverty level.

It is therefore extremely important to expand Medicaid eligibility to the maximum permitted by the federal government. The federal government would match every dollar New Jersey spent on Medicaid. Moreover, expansion of Medicaid eligibility would in many ways work to restrict the growth of uncompensated care.

50X

In enacting the most recent version of the Uncompensated Care Trust Fund law, the Legislature mandated the Trust Fund Advisory Committee to explore financing options for the Fund other than the current method of marking up hospital charges. The Trust Fund Advisory Committee, in developing alternative financing arrangements, "recognized the importance of maintaining the hospital uncompensated care mark-up as a fall back financing mechanism for any residual uncompensated care--in the event other funding sources being implemented fall short of expectations in a given year, due to subsequent legislative action or inaccurate revenue or uncompensated care cost projections."

Legal Services of New Jersey emphatically endorses this statement. It is the only way to ensure that all hospitals continue to provide uncompensated care to those who are eligible and are equitably reimbursed for doing so. We note that the former Commissioner of Health specifically recommended the retention of the hospital mark-up system as a safe guard in the even that other financing mechanisms are not adequate to fully fund uncompensated care.

The Commissioner of Health also noted, and we agree, that if the Trust Fund Advisory Commission's recommendation for an initially reduced mark-up is accepted, this would result in reductions in state spending for the Medicaid program and the state employee benefits program. She suggested that the State's portion of the Medicaid expansion could be fully funded by the savings to the state resulting from the lowering of the hospital mark-up. Legal Services of New Jersey is of the view that if alternative financing is introduced and does result in reduced costs to the State, as well as other purchasers of hospital services, the savings to the State should be applied to the cost of expanding Medicaid eligibility thereby attracting matching federal dollars.

NEW JERSEY PSYCHOLOGICAL ASSOCIATION

349 East Northfield Road, Suite 211, Livingston, NJ 07039
(201) 535-9888 • (609) 482-8866 • FAX (201) 535-6451

Members of the Assembly Health care Policy Study Commission:

My name is Gordon Boals. I am a licensed psychologist and I am representing the NJ Psychological Association. We are grateful for your interest in health care and insurance matters and for the opportunity to present to you some of our concerns.

Mental illness affects one person in ten in our population. Providing treatment not only relieves the pain and suffering but provides many other social benefits as well.

1. Successful treatment allows people to return to the work force or to become more creative and productive. Their higher earnings generate tax dollars and reduce social welfare costs. In addition, studies show that psychotherapy reduces absenteeism, employee turnovers, and accidents.

2. Secondly, psychotherapy has been shown to reduce other medical costs. As many as 2/3 of all visits to doctors are estimated to arise from emotional problems. It is a truism today that stress, and maladapted ways of coping with it, such as alcohol and drug abuse, aggravate medical problems.

Outpatient mental health expenditures are usually estimated as constituting only 3% of health expenditures, a very small proportion indeed! And they are not implicated in the rapid increases in health expenditures because they are wage costs;

most of the increases in health expenditures are capital costs due to expensive new machinery and hospital buildings. Nor are they particularly affected by the explosion in malpractice insurance rates. Those rates have remained stable and very low in the mental health field.

Consequently, mental health expenditures should not be viewed as part of the problem of soaring health costs; rather, as suggested before, they should be viewed as part of the solution. It would make no sense to reduce mental health expenditures to control health costs. In fact, an increase in mental health expenditures is more likely to lower total health costs.

How should mental health care be financed? There are two basic options: (1) treatment can be publicly funded through taxes and be delivered through mental health clinics and community mental health centers or (2) it can be funded privately through health insurance plans supplemented by individual co-payments.

The existing problem of budget deficits makes the former approach - publicly funded clinics - impractical. Furthermore, since Federal support to community mental health centers has ended and they are now expected to be self-supporting, a major source of revenue for these clinics has been medical insurance benefit payments.

So, if private health insurance appears to be the most reasonable and practical way of funding mental health treatment, what problems exist with such funding and what can be done to guarantee appropriate care for all citizens to mental health care?

First, since not everyone is employed or has health benefits, there is a continuing role for publicly funded mental health clinics which will treat people regardless of ability to pay.

Secondly, it is necessary to set minimum standards for mental health coverage in private health insurance plans. At present, insurance companies competing to offer lower cost health insurance and employers eager to reduce their costs, may cut mental health benefits to little or nothing in the expectation that employees may not complain. Even where benefit packages are determined by collective bargaining between workers and management, mental health benefits may be traded away for other items (it is not always easy for consumers to speak up about how important mental health treatment is to them). As I stated before, society has an interest in having mental health care available and affordable to those who need it. So, it is appropriate to set minimum levels of treatment and maximally accepted levels of co-payment which should be provided in all insurance plans. Optimally, mental health should be required to be reimbursed at the same rate as other illnesses which is not usually the case.

There is precedent for this approach of mandating minimal levels of care in the reimbursement of expenditures for pregnancy and childbirth. At one time, all medical expenditures related to pregnancy and childbirth were excluded from health insurance on the grounds that these were voluntary expenditures and pregnancy was not a disease. But then society decided that it had an interest in having healthy babies and most states required all health insurance plans to cover pregnancy and childbirth.

So too with mental health benefits. Many states have mandated minimum levels of mental health care that must be reimbursed under health care insurance. But not New Jersey. We would like to see minimum levels of mental health coverage mandated in this state as well, to guarantee that all workers would have access to a satisfactory level of mental health care.

I thank you for your consideration.