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

before

SUB -COMMITTEE ON HEALTH CARE COSTS

of the

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

Scope and Extent of Health Insurance Coverage in New Jersey

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Senate Chamber
State House
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MEMBER OF SUB-COMMITTEE PRESENT:

Senator William J. Hamilton, Jr., Chairman

ALSO:

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I N D E X

I N D E X - Continued

SENATOR WILLIAM J. HAMILTON, JR. (Chairman): It being ten o'clock legislative time, we will commence this morning's hearing.

I am Senator Bill Hamilton. I expect during the course of the day one or more members of the Senate Institutions, Health and Welfare Committee will probably be joining me for this committee hearing.

This is the first meeting of the Senate Institutions, Health and Welfare Subcommittee on Health Care Costs. The subcommittee was formed to serve as a focal point for the Senate's medical cost efforts and to provide a vehicle through which current and proposed legislation dealing with health care costs can be reviewed and discussed. I have every expectation that effective legislation to improve the State's health care delivery system and to reduce health care costs will result from the work of this subcommittee.

Some of the issues that we propose for the subcommittee to examine are: first, the scope, extent and cost of health insurance coverages and plans in the State; second, the need for and the fiscal feasibility of a State program of catastrophic health insurance; third, the fiscal problems of urban and other hospitals; and, finally, the extent to which expansion of Medicaid to include a medically needy program will meet the need of families unable to pay for health care and of institutions that are under compensated or uncompensated for the medical services they provide.

You already know that one thing about the process that we have begun publicly today - although there already has been staff work done before today - is going to be the same as it has always been in the Legislature and that is: we are not starting on time. I hope that something else is going to be different. I intend that the approach we take with respect to these issues and the problems we are going to talk about is going to be different in at least one significant particular. As I look around the room I recognize that most of you are inveterate, if that is the right word, legislative watchers. You know that we usually learn about a problem in the manner of volunteer firemen rushing to put out a fire, but infrequently stopping to examine the root causes and the probable long-term consequences of the solutions that we propose. What I hope will be different about the efforts that we undertake with you today is that we are not going to start with the answer. We are not going to start with Assemblyman A's bill or Senator B's bill. We are going to start with a range of issues that is, on the one hand, broad because it covers much of our health care delivery system and, on the other, narrow because it focuses on the economics of that system. Why pays for it? Why the great increase in cost? And how we can provide coverage.

So, we are going to start, not with the answer, but with the questions that the problems suggest. Hopefully, when we are finished, we will come up with some answers. I think that approach is different than the way we usually proceed. I am delighted to start out with you and I want to emphasize that this is not a public hearing in the usual sense of that word. It is a hearing of the subcommittee. It is open to the public, as indeed all of our meetings are. We are not here to give voice to the answers we have already reached, but rather in as real a sense as possible to get the input of those of you who are knowledgeable about the problems we will talk about.

We have chosen to initiate the subcommittee's work by inviting you principal participants in New Jersey's health care system to present your views today as to the several critical and related areas that we expect to be studying

and to get your input as to possible solutions to the problems that are related to those issues. To the greatest extent possible, I would like today's hearing to lay the groundwork for the subcommittee's ultimate recommendations and report.

Let me share with you briefly, because today I intend to listen, hopefully, more than to talk - although I guess those of you who know me recognize that my good intentions in that regard frequently are treated like my New Year's resolutions - what I see as the economic backdrop of some of the issues that I think are appropriate for this subcommittee's attention. A logical beginning is some of the data associated with health care costs.

The total aggregate national health expenditures in the 20 years from 1950 to 1970 increased by $62.1 billion, about $3 billion a year. That is over a 20 year period. In the next eight years, from 1970 to 1978, similar expenditures increased by $117.7 billion or about $14.7 billion a year. That is about a five-fold annual increase. Total health expenditures as a percent of gross national product increased from 4.5 percent in 1950 to 9.1 percent in 1978. That is a doubling.

The total state government - for all states - health care expenditures in the eight-year period that we have just referred to, 1970 to 1978, tripled from $8.1 billion for all 50 states to $28.3 billion. As a percent of total state budgets, health expenditures increased from 10.4 percent to 13.9 percent.

If we look at a different measure, the Consumer Price Index, and compare all items in medical care, we see very clearly that medical care costs are increasing much faster than other items. In the same eight-year period from 1970 to 1978, the Consumer Price Index for all items increased 68 percent. Many are appalled by that. However, the CPI for medical care increased 82 percent.

The effect of these tremendous cost increases are acute. A large portion of our population remains without medical insurance of any kind. A larger proportion of our population carries inadequate medical insurance. I use the word "inadequate" meaning that the people who have the coverage are unable as individuals or as families to meet a significant portion of their total medical expenses. I mean inadequate in no other sense at this time.

Many low income families and individuals can't meet the eligibility requirements for state medical programs and are, therefore, unable to afford the tremendous burden of major medical expenses. Only this weekend, in the context of very happy news that a young woman whose family is an acquaintance of mine is home after a lengthy bout in the hospital with leukemia, I heard the family had received a bill in excess of $100,000. Theirs is a very modest, middle-class family.

This subcommittee will be the focal point from which the Senate will aim its second generation health cost efforts. All of us have great expectations about the cost containment bill, the Hospital Rate Setting Bill. Obviously, there will be more that has to be done. We hope to be a channel through which health cost legislation can be developed and evaluated.

Judging simply from the impact on the cost of living, the issues that I have articulated are some of the most important facing us in New Jersey today, indeed, facing us in the country. National attention for some time has been focused on the catastrophic effect of sudden, unexpected and precipitous medical costs. Many of us thought that we would have a real exposition of those issues during the presidential primary season just completed because both Senator Kennedy and President Carter had addressed themselves in serious fashion to those issues.

We all now know that the primary season concluded with perhaps two words having been said about the two different approaches to providing health care. Issues of probably far less consequence, certainly of short-term impact, on the American people and on the people of the State of New Jersey occupied and preoccupied the media and the voters of the country.

Some would say that there is no state role. Some would say that you should not be here today and, certainly, that I should not be here today. That suggestion, that position, is not without some merit. I concede that from the outset. But I would make this observation about the federal process - and those of you who are not only state legislative watchers but congressional watchers, I think will be compelled to agree with me - that a federal solution or federal action in this area is likely to have three components. First of all, there will be tremendous delay. It will be years before the conflicting points of view and any kind of program will be developed at the federal level. Secondly, the federal program when it comes will involve absolutely tremendous amounts of money and it will, if the track record holds true, involve tremendous overregulation of all aspects of the health care system. Finally, and perhaps most significantly, is that the federal response will operate on a premise that government and government action is going to be the solution to the problem. I don't have that feeling. I have the feeling that there are important people here from State government who are going to make a contribution to whatever effort the State of New Jersey can make and can accomplish.

I have an equally clear impression and belief that those of you from the private sector are going to be in the front line of whatever effort we can make. As an individual legislator and as an individual citizen, I have come to believe over the nine years that I have served in the Legislature, if there is one thing that government does very well, it is to assume too much about its capacity and capability to solve serious social problems that have an economic impact. I hope whatever we come up with gets rid of that basic assumption. It is in large measure, I think, the reason there are state laws in some of the areas that I have talked about, especially in terms of catastrophic illness. Whatever we can develop I feel can be developed best in a public-private partnership and the public good will be served because of that partnership.

Without going on at too great a length, let's talk just a little bit about those four areas.

Catastrophic health costs are those costs either large in absolute expenditures or expenditures that are large in relation to an individual's income or a family's income. The lack of adequate basic insurance coverage for almost one-third of the families whose incomes are below the national median in the absence of both public and private health insurance programs to cover certain types of services has resulted in two kinds of catastrophic out-of-pocket expenses. The first is the cost of long-term care for the aged and the second is the average or normal expenses that consume an unreasonable proportion of a low income family's resources.

Medical indigency is another problem of major significance in the health costs scheme. Medically indigent people are those who do not qualify for Medicaid because their incomes and resources are above current eligibility standards. But those same incomes and resources are insufficient to meet necessary medical costs. They may also be people who are on Medicaid but who need long-term care services not provided by Medicaid.

It is my belief - and perhaps I have already said some of this - that we must start our analysis and make our recommendations from three very fundamental principles.

The first is that government should not be trying to provide a service private enterprise can and is willing to provide at a reasonable cost and with reasonable competence.

The second is that no family in our society should be forced into financial ruin by the cost of staying healthy and the corollary to that is that no family in the depths of poverty should be denied essential medical care.

Finally, every health care institution which provides medical services in good faith to the needy should be protected from substantial financial loss.

Putting these goals together with the t r e m e n d o u s problems associated with the cost and delivery of health care, many of which we have come to articulate today, will most certainly be a sobering experience for all of us. But we have assembled in this chamber today some of the best people in the fields that we are talking about and I believe some of the brightest minds in the business.

Today's hearing, the first of at least a small number, will focus on the scope, extent and cost of health care coverage. We hope to determine who are the major providers of health care coverage in the State; what type and extent of coverage they provide; who is covered and, conversely, who is not covered; and how is this coverage purchased, by employers, labor unions or privately. We will hear testimony today from representatives of the insurance industry, health care providers, labor unions, State government and, of course, the public. Hopefully, today's testimony will help us clarify and define the major issues concerning health care costs that this subcommittee was structured to consider and will be addressing during the next several months.

I have come here today to commit my best efforts to bringing the problems into focus and achieving our goal: a health care system for New Jersey that is efficient, effective and compassionate. I am very appreciative of the fact that you are joining me in that effort.

We have a number of you who have expressed interest in testifying today. I have all of those names. At this point, I do not intend to follow a certain order of procedure. I am going to try to remain somewhat flexible in terms of proceeding in a logical fashion with respect to the testimony that we are taking. I am going to start with some insurers and health care providers. I will then probably proceed to one or two members of the public who have certain information they want to convey to us about their own experiences with certain State programs. I want to hear as well during the course of the day from several people in several of the departments of State government that deal very significantly with health care issues.

I would ask any of you who have a particular problem to so advise us. I intend to stay here until we can take a full day's testimony and reach everyone who is here. I warn those of you who testify that I will probably get into some dialogue with you and that won't bother you nearly as much as it will the fellow who is sitting behind you waiting to testify next. But those of you who do have a scheduling problem, if you will communicate that to Mrs. Eleanor Seel, who is the very able staff person for this subcommittee, as well as to the Senate Institutions, Health and Welfare Committee, and is seated to my left and will be with me throughout the day, you will be accommodated. If Mrs. Seel should be occupied and you feel

it necessary to communicate with someone, Mrs. Artea Lombardi from my staff, is seated near Senator Parker's seat.

With that, I would like to begin by calling on Mr. Joe Walsh and Mr. Jeff Lyon from Blue Cross and Blue Shield to come forward and let us have their views.

J O E W A L S H: My name is Joe Walsh. I am with Blue Cross. We are very pleased to participate today and we certainly commend the approach being taken to what is a very difficult problem, the solution of health care and health care costs in New Jersey.

Earlier in the Spring, Eleanor Seel had approached us about some statistical information on the number of people covered by Blue Cross by type of contract, which we have provided. We spoke to Eleanor a little later this month, and she indicated she would like a further explanation of the coverages in order to give you a little background information. We have provided this information. It indicates that currently under Blue Cross coverages we have some 3,670,000 enrolled under group coverage in New Jersey and some 899,000 under direct pay coverages in New Jersey.

SENATOR HAMILTON: What was the second number, please?

MR. WALSH: 899,000 under direct pay coverages, where people are paying individually.

We stand ready to answer any of your questions concerning our coverages. I have brought some people with me today who are much more expert than I in the specifics of our benefits and we would be happy to respond to your questions.

SENATOR HAMILTON: Thank you very much, Joe. Do you have any information with you at this time, if not, can you get it for us, that would enable us to quantify the size of the claims that are made to Blue Cross and Blue Shield by group, that is, by any categories you may choose to use, up to $200, $200 to $500, $500 to $1,000, $1,000 to $2500, any kind of range like that?

MR. WALSH: I do not have this information with me today, but we certainly can provide the sub-committee with any information in that regard, yes.

SENATOR HAMILTON: It is reasonably and readily available?

MR. WALSH: Yes, we can obtain it. It will require some computer runs, but we can obtain it, yes.

SENATOR HAMILTON: What I would like to have in connection with that, in addition to the structure of the claims to the extent that you know the proportion of the total bill that those claims represent - not individually, but again by group or average amount, that kind of thing.

MR. WALSH: Fine.

SENATOR HAMILTON: Of the group coverage, the 3,670,000 covered by group coverage, what proportion of that almost three million seven is paid for in whole or in part by someone other than your member?

MR. WALSH: We don't have a figure on that, because what we do, we obtain premiums from the group. We would get the premium payment from the group. The group is left free to determine what type or amount of employee contribution is applied to that. However, I can safely say that the great

majority of the coverage is paid for by the group and many groups pay for the Blue Cross coverages in full for their employees.

SENATOR HAMILTON: Maybe I am a little premature with that question. When we say group coverage, what are the standards that would enable someone to be a group, and what kind of groups are we typically talking about that make up the bulk of the three million seven?

MR. WALSH: We are talking in group sizes of normally 50 to 100 people. That is a very common group blocking. But, we will take group enrollments of groups as small as four to ten people, I believe. And then we go all the way up to the giant national accounts, which is the United Auto Workers, and U. S. Steel, et cetera.

SENATOR HAMILTON: Would these groups be typically employers, that is, businesses and labor unions?

MR. WALSH: Yes, they would be employers, labor unions, and in some instances professional associations.

SENATOR HAMILTON: Like the Bar Association?

MR. WALSH: Yes, that is correct.

SENATOR HAMILTON: Is there any significant number of fraternal groups that are buying coverage of that kind?

MR. WALSH: No.

SENATOR HAMILTON: Elks, Knights of Columbus?

MR. WALSH: No.

SENATOR HAMILTON: In order to have the data as to the percentage of total premium cost that is paid by the group, we would need to make that inquiry of individual groups.

MR. WALSH: That is correct, Senator, that would not be on our records.

SENATOR HAMILTON: Is there to your knowledge anywhere within the industry, either in New Jersey or on a national level, any data that is available with respect to that?

MR. WALSH: Not to my knowledge. I don't know if the Health Insurance Association has any statistics on that.

SENATOR HAMILTON: We will see when they come forward. I take it from what you have said that your impression is that a high proportion, and frequently the total proportion of the cost is paid by the group.

MR. WALSH: Yes.

SENATOR HAMILTON: But, you are not holding that out as fact; you are holding that out as to experience and impressions you have gathered through your experience.

MR. WALSH: That is correct.

SENATOR HAMILTON: Are you able to tell us anything at all relative to the extent to which your participants have overlapping coverage?

MR. WALSH: Duplicate coverage?

SENATOR HAMILTON: Yes.

MR. WALSH: Again, we do not have statistics on that. Where we do find a case of duplicate coverage, we notify the group or the individual in question and bring this to their attention. There is also a coordination of benefits provision where we insure that we review claims that we are not paying under two coverages.

SENATOR HAMILTON: When I asked the question about overlapping coverage, I don't mean coverage with Blue Cross through two different groups. I mean coverage through Blue Cross and coverage through some other kind of policy or benefit.

MR. WALSH: Yes.

SENATOR HAMILTON: Does your answer respond to that as well?

MR. WALSH: I will elaborate a bit on that. There is a coordination of benefits provision in the law which allows us, where we can find two group coverages, the individual policies can be reviewed, and one is determined primary if there is a pecking order as to who is primary.

It is my understanding that where an individual purchases direct pay coverages on their own, that the coordination of benefits provisions do not apply. So, if someone wishes to insure themselves with duplicate coverages on their own, they are allowed to do so.

SENATOR HAMILTON: Do you have any kind of an age profile with respect to your covered members?

MR. WALSH: We would have an age profile or could obtain some age statistics for you as to the enrollees, the people who have the coverage. It would be difficult - although we have some growth statistics - to find out statistics as to dependents and spouses ages, et cetera. But, we could get some figures for you, yes. But, we would use those in actuarial projections.

SENATOR HAMILTON: Mr. Walsh, or Joe, if I may, without putting any pressure on you as to time, what is a reasonable time that you think we can get some of the kind of data that I have asked for today - just for planning purposes, with respect to age, size of claims submitted for reimbursement.

MR. WALSH: It is difficult to say, because I don't know what type of computer gyrations are involved. Let's say two weeks.

SENATOR HAMILTON: All right, and if we don't have it then, could you just let us know the progress you have made.

MR. WALSH: I will let you know immediately what the difficulty will be.

SENATOR HAMILTON: Do you as a matter of planning or policy within Blue Cross attempt to make any determination on either an individual or group basis? Or with respect to marketing activities concerning the adequacy of coverage, and the adequacy of benefits? What, if anything, is done by Blue Cross in that area?

MR. WALSH: All right, on our group coverages, of course, we do counsel perspective clients and try to tell them of the difficulties they may have if they buy lower level coverages. Actually, all of the Blue Cross coverages are pretty high standard. There are very few calls for hospitalization, if any. The main options are on the number of days of full coverage one buys, 120 days versus 365 days. But, both these coverages are quite complete.

SENATOR HAMILTON: Are any of the Blue Cross plans individually tailored, or are there four or five on the shelf that are taken off and marketed?

MR. WALSH: There are for our direct pay or subscribers, people who are buying insurance directly. There are several standard packages that we offer. We also offer a package for individuals who cannot get insurance, who have serious health impairment. We have a continuing open enrollment, and that is a separate package.

For our groups we have several standard packages to sell to what we call the domestic master groups. But, for our larger national accounts, and our larger groups, we will tailor a package to the groups' needs.

SENATOR HAMILTON: To what extent are some or all of those policies or the specimens thereof on file with the State Department of Insurance?

MR. WALSH: They are on file.

SENATOR HAMILTON: All of them.

MR. WALSH: That is my understanding, yes.

SENATOR HAMILTON: So, to the extent that we want copies of those, we can get them as easily from our own resources as we can from you.

MR. WALSH: Yes, and if you can't we would be happy to supply any of them to you.

SENATOR HAMILTON: I appreciate that. Were the State through its corporation business tax or otherwise to limit the deductibility of an employer's expenditures for the group health insurance coverage through Blue Cross and Blue Shield from that tax, unless the coverage has met a certain standard, what problems, if any, would that present with respect to your larger plans that cover employees in more than one state?

MR. WALSH: I don't believe it would present a problem simply because the coverages for employees intra-state or our national accounts are usually the most complete packages. They are very complete, and I think they would meet your standards.

As far as a New Jersey law applying to these accounts, I am not sure how that would work, but in some other aspects, because it was intra-state, there was a restriction on whether New Jersey law would take effect on these national accounts.

SENATOR HAMILTON: Well, the way I postulated the question, there is not a law that would mandate certain coverages.

MR. WALSH: A minimum standard.

SENATOR HAMILTON: No, it would limit the deductibility of the employees expenditures as a business expense, and would thereby be a tremendous impetus for the employers if his coverage didn't meet the standards to upgrade, which could mean more revenue but could create some problems. That is the reason I asked the question.

MR. WALSH: Again, I would not anticipate a problem, because I think that the coverages are quite extensive and would probably meet any minimum standards you might have.

SENATOR HAMILTON: If I understand what you are saying, you are bragging a little bit about your coverage generally. And, within that range, you are saying that the coverages that apply to a multi-state employer are among the broadest of the coverages you offer.

MR. WALSH: That is correct.

SENATOR HAMILTON: From your point of view, does New Jersey, through its regulations or its economic policies or tax policies or otherwise, do anything to encourage coverage for employees by an employer, and do we do anything, again by way of state policy, to encourage that those coverages be "adequate" with respect to those employees?

MR. WALSH: Well, yes, I feel that both the Department of Health and the Department of Insurance and to a degree, the Public Advocate's Office, do continually meet with us to encourage us where they see there is a benefit gap or a problem to upgrade coverages. We evaluate these, and in many instances we have added coverages. In other instances we have offered to some accounts separate riders to provide more extended benefits.

SENATOR HAMILTON: What is the standing procedural vehicle, if there is one, by which that exchange takes place, the exchange between the Department of Health or the Department of Insurance and Blue Cross and Blue Shield?

MR. WALSH: There is not a formal vehicle with the exception, perhaps, when a rate filing is made by Blue Cross. We often have hearings where this exchange does take place. But, the informal and day-to-day communications on a number of matters with insurance and the Department of Health, particularly, are such that these matters are frequently discussed, and are fairly aired.

SENATOR HAMILTON: Everything from an unplanned luncheon meeting that two people bump into each other on up through appointments that are scheduled either by the private sector or by the State.

MR. WALSH: That is correct.

SENATOR HAMILTON: Also, you indicated in the rate filing process - where I assume that while at some point the Public Advocate may be in an adversarial role, there is also a lot of meeting and probably some negotiation in that process; is that right?

MR. WALSH: That is correct, Senator.

SENATOR HAMILTON: Again, attempting to quantify, do most of the exchanges and encouragement - because that is what started this question - by State Government, come in the day-to-day environment, or do they come in the rate setting environment?

MR. WALSH: I believe that the majority come in a day-to-day environment. The rate setting is not that frequent. And, we are continually hearing the complaints of the public -to us directly or through a State agency-and adjusting and adapting coverages.

SENATOR HAMILTON: You anticipated my next question. I am sure you have an element within Blue Cross that does respond to the enrollee's complaint about I had "x", "y" or "z" expense and you didn't pay it or you say you are not going to pay it. How is that structured internally?

MR. WALSH: Well, we have an extensive inquiry area where the public can inquire about benefits. If they are not satisfied with the answer, it goes right up the ladder, as with most organizations, and we try to explain our rationale for our benefit structure and why,if a particular item is not covered, it is not covered in the contract.

SENATOR HAMILTON: What policy making vehicle exists, if any, within Blue Cross for making a change, even though your present coverages may be "x". What if there is good cause suggested for expanding it to "x+y."

MR. WALSH: We have a standing committee in Blue Cross which is made up of various areas of the plan to include the actuarial areas, our Medical Director's Office, and the people with provider experience, economists, et cetera, who evaluate requests for benefit modifications according to the cost of these benefits, the need for these benefits to the public, the extent of

these services which would be covered by these benefits, et cetera, and they would recommend to the senior management of the corporation modifications in benefits.

SENATOR HAMILTON: Other than the kinds of exchanges that you have just outlined for us, is there anything in the Title 17 generally--- Are you covered by Title 17?

MR. WALSH: Yes.

SENATOR HAMILTON: ---in Title 17 generally, or in the tax laws in the state that encourage at all in the vein in which I have previously questioned you about deductibility - the providing of coverage in the first instance, or the expansion of coverage? Is there anything that you are aware of at all?

MR. WALSH: I am not aware of anything, are you, sir?

J E F F E R S O N L Y O N: I am Jefferson Lyon representing Blue Shield today.

SENATOR HAMILTON: And not a stranger to these chambers.

MR. LYON: The enabling act of both Blue Cross and Blue Shield gives the Commissioner of Insurance broad authority to make sure that our coverages and the rates therefore are adequate at all times in his judgement and never unfairly discriminatory as the rates are benefits.

SENATOR HAMILTON: That is for the protection of the consuming public, so on the one hand they are not gouged, and secondly that you were being fiscally solvent on the other. In terms of policy where the State says we would like to see people have more benefits available because of escalating health costs, is there any specific statutory or regulatory provision - like the deductibility provision that I talked about before in the corporation business tax that exists, as far as you know?

MR. LYON: That would come through the legislative route, I think, Senator. And, of course, our position has always been that it is desirable to offer that as an optional availability to the group that needs that sort of coverage. It gets costly sometimes when well-meaning legislators mandate benefits without also providing a way to pay for them.

SENATOR HAMILTON: Having been a part of some of those legislative discussions in the past, I understand what you are saying. But, I take your answer to be that except for those kinds of mandated coverages and psychologists and chiropodists, and alcoholism coverages, that is the kind of thing you are talking about.

MR. LYON: Right.

SENATOR HAMILTON: There isn't anything that is broader in range in terms of the premiums being deducted from a corporation business tax or perhaps going to an absurd extreme, you can't do business in the State of New Jersey unless you provide "x,y,z" coverage that exists to your knowledge?

MR. LYON: Well, of course, there recently was passed some legislation by Mr. Bornheimer which does support the Commissioner of Insurance's authority to maintain standards. Over the years, in our experience he has found ways to encourage us where he thinks it is necessary to meet needs.

We cooperatively worked out with him, as you may recall, four or five years ago, the on-going open enrollment concept which lets people who

ordinarily wouldn't have been deemed insurable by anybody have Blue Cross and Blue Shield, no questions asked.

SENATOR HAMILTON: Jeff, you have anticipated again my next question. I am content to continue with you, but I don't want to be the vehicle for having Mr. Walsh give us his seat unless you both agree that is what you want to do.

MR. LYON: Either way, I will continue.

SENATOR HAMILTON: Assemblyman Bornheimer did move and the Legislature adopted and the Governor signed Chapter 58 of the laws of '79 and you have described that as enhancing the Commissioner's power to set some minimum standards with respect to coverage.

Would you comment on that legislation, the promptness with which the standards have been developed, how you are finding the standards in terms of having to deal with them, and any other comments you care to make about the legislation.

MR. WALSH: I have no comment on the legislation. I really would like to opt to Mr. Lyon on this one who was present during those negotiations.

MR. LYON: Well, actually the standards legislation that Mr. Bornheimer's bill brought into play really didn't have a very profound effect upon the Blues, because of the fact that we operate under special enabling acts, and actually the hue and cry which brought the Bornheimer hearings and the bill into play was very well founded, because there were some insurance companies and agents, none of whom I am sure represented in the room today, because the major insurance companies such as Prudential and the Blues supported this entire inquiry, which, as you may remember, has its origin in the series in the Newark Star Ledger started by Herb Jaffee.

SENATOR HAMILTON: I think those kinds of problems are beyond certainly the scope of this particular subcommittee, but those are significant issues that are not really a part of our game plan here.

MR. LYON: Basically that is what Bornheimer was all about.

SENATOR HAMILTON: Are the regulations currently in effect, or have they been delayed?

MR. LYON: I think they are in effect today. I think probably Joe Frankel who operates under that section of the locket could throw some light on that one.

SENATOR HAMILTON: Well, we are going to hear from Mr. Frankel this morning and I have not tried to show any favoritism as between you, but since I have heard you throw the numbers out of 4.6 or whatever numbers I see around very frequently--- Because I think you figure I took you first, and I love you both, but---

MR. LYON: Senator Hamilton, now that I am representing only Blue Shield I am down to 4 million even.

SENATOR HAMILTON: Okay. Let me ask you this: The Bornheimer legislation, and I think it is significant legislation, was a less all encompassing piece of legislation than the Hagedorn bill which originally was a part of the discussions within the full Senate Institutions, Health and Welfare Committee at the time we talked about the hospital rate setting bill. What about a concept like Senator Hagedorn's bill?

MR. LYON: Senator Hagedorn's bill was Senate 419 at the time S-400 was being considered, and his original---

SENATOR HAMILTON: Please don't ever say S-400. It was S-446. S-400 has certain other connotations to someone of my political philosophy.

MR. LYON: S-446, correct. Mr. Hagedorn's bill at that time basically did one thing. It put all the commercial health care carriers under the similar regulation that is undergone by Blue Cross and Blue Shield, period. That is about all that Hagedorn's bill did.

SENATOR HAMILTON: You are saying that S-419 had no particular impact on the blues; that its impact would have been on commercial insurance?

MR. LYON: It would have had a substantial impact on the commercial insurance companies, and would have given us a flat-footed, even, competitive stance.

SENATOR HAMILTON: Well, it didn't get very far in the Committee at that time, as I recall it.

MR. LYON: It was amended, and the amendments have been quite helpful to us.

SENATOR HAMILTON: Well, the amendments had to do with the discount that you were entitled to in connection with the rate setting process, as I recall.

MR. LYON: That is correct, and also S-419 as amended gave us a little more flexibility in our underwriting powers. It still left us under the strict regulation of the Insurance Department and our special enabling act. The differential between what we pay to hospitals and what Joe Frankel pays hospitals came into play under S-446.

SENATOR HAMILTON: Okay. Well, I am certainly going to hear from Mr. Frankel before the morning is out. But, I understand your answer to be that S-419 as originally proposed had no substantial impact on the blues.

MR. LYON: No, it didn't except that it would substantially improve our competitive posture, and it did improve it to a degree as amended.

SENATOR HAMILTON: I am trying to recapture in my mind, although it is not terribly important, was your position then one in support of S-419.

MR. LYON: Yes, sir, as we supported S-446 as it was finally worked on.

SENATOR HAMILTON: We all had great hopes and still have great hopes for S-446, but I made some observations at the time we were in that about the indirect tax that was being imposed, and it is in part as a result of that, because I think that is still true, that we are here today talking about some other matters.

To the extent that you consider it, when we talk about adequacy of coverage, from the point of view of Blue Cross-Blue Shield, what is adequate, or what should be the minimum coverage that is available. What standards do you use in evaluating that?

MR. WALSH: The standards changed because the methods of treatment changed. Currently, for instance, a lot more is being done on an outpatient basis, rather than inpatient basis.

Originally, our coverages were primarily aimed towards comprehensive, inpatient benefits, and as things begin to be covered more or be treated more, I should say, on an outpatient basis with medical advances making that possible, the majority of our adjustments in recent years have been towards providing extended, outpatient benefits.

SENATOR HAMILTON: Without curtailing in-hospital benefits?

MR. WALSH: Without curtailing in-hospital benefits. We try and encourage things to be done on an outpatient basis, for instance, same-day surgery which we have worked very hard with the hospitals over the last eight to ten years now occupies a substantial percentage of our surgical cases and is a considerable savings.

We do also medically review inpatient cases as to PSRO's for the government programs to insure that a service which is rendered on an inpatient basis required that the patient be hospitalized and could not have been performed on an outpatient basis. We can't be taking stands and encouraging things such as that unless we have provided, we feel, in our benefit structure for that outpatient alternative.

SENATOR HAMILTON: My aide, Mr. Damico, would like to be reassured by you that the same-day surgery is very safe for adults about to undergo tonsillectomies, because he may find out on Monday.

There is a lower reimbursement--- I am going to put a question mark at the end. Let me just rephrase that. Is there a lower reimbursement for same-day surgery than for a situation where a patient will remain overnight for one or more days in the hospital?

MR. WALSH: On the Blue Cross coverages, if the person remained overnight, or whether they received same-day surgical treatment, the coverage would be paid in full. It is paid on a different basis, inpatient being paid on a per diem basis, and outpatient being paid on a charge basis with the exception of the hospitals that are now on the DRG system, which is another animal. But, the coverage would be payment in full.

SENATOR HAMILTON: That makes it hard for me to find out which is more expensive and which is more expensive---

MR. WALSH: The inpatient is more expensive. Although an inpatient payment on a per diem, the dollar amount or the specific claim we might pay that inpatient case might be lower actually than the charges we would be paying for an outpatient, since there is a year-end reconcilliation as to actual costs. In essence, the inpatient would be more expensive.

SENATOR HAMILTON: What incentive, if any, exists for the hospital without compromising the quality of patient care. Will the physician with the same consideration not compromising the quality of care exist to encourage the one over the other?

MR. WALSH: Currently, with the advances, again, in outpatient surgery there is an incentive, because there is a physician incentive for the outpatient surgery because it is being seen as a more acceptable and desirable route by a great segment of the population to go. So, the physicians have encouraged hospitals to provide facilities for outpatient surgery, and I am sure it affects the hospital that the physician chooses to practice in - if they do not provide this facility.

Under the DRG system, where, in essence, a hospital is trying to go towards a standard cost per diagnosis, if the end result will be that it will be that it is cheaper, less expensive, and just as safe to treat a patient on an outpatient basis, there is an incentive for them to follow that route and therefore come in lower than the norm statewide.

I think that the hospitals in this regard - and I am sure you will speak to the hospital representatives later today - have been quite progressive.

SENATOR HAMILTON: I think we could maybe spend the whole day talking about the economic consequences of DRG. I think I better know a little bit more about it before I try to talk to you at all about that.

Are there significant areas of coverage where for economic reasons, consumer demand, or otherwise, there are presently gaps in coverage?

MR. WALSH: Significant is a difficult term. We don't believe so. We think that in making any additional coverages available you have to be sure that the liberalization of the coverage does not lead to abuses, does not lead to people who are seeking coverage who really should be going to a physician's office for this coverage as opposed to a hospital setting. There are the types of considerations we weigh very carefully. We are interested in providing people with the types of coverage they expect so they are insured properly when they receive treatment. But, at the same time we have to do that at a cost which we believe is reasonable and we have to discourage wherever we can seeking medical treatment at a higher level of care than is required.

SENATOR HAMILTON: Without giving away any trade secrets to Mr. Melman or Mr. Frankel, or anyone else who might be here, what are the factors that would probably lead to a dramatic increase of enrollment in Blue Cross-Blue Shield from the viewpoint of getting health care consumers who are not now enrollees.

What kinds of things in terms of state or federal payment, state or federal policy or other things just short of your own marketing activities, what are the kinds of governmental policies that would lead if it were deemed to be good social policy that there be increased enrollment in Blue Cross-Blue Shield, and additional policies purchased from Prudential and others. What kinds of policies would leave it up, in your view; what sort of incentives, if there were incentives to give?

MR. WALSH: Your question is, what types of incentives can you give people to avail themselves of coverage, right.

SENATOR HAMILTON: Yes.

MR. WALSH: I suppose it is the pocketbook. Again, if we feel that through the commercials and ourselves there are coverages available at the most reasonable possible price to the individual, Blue Cross has an open enrollment policy where people who have serious health impairments can be enrolled, and of course at any time an individual can apply for coverage and everyone is accepted, either one way or the other.

Again, not to get into the DRG or the S-446, one of the major factors, I think to encourage a person to obtain coverage was the fact that if they did not pay the bill, they would be dunned and chased by the provider who provided

the care, and I don't know if the provision in the new law of providing hospitals after some collection efforts with a guarantee of their bad debts, if they do not collect it from these individuals, will have a beneficial effect on encouraging people to get additional protection for themselves.

SENATOR HAMILTON: Well, let me ask you this: Assuming and adult person, young or old, publicly unemployed with one of the more serious forms of cancer, but who survives, assume a young person or an adult who suffers what I would suppose you call an orthopedic injury that renders him a quadraplegic. To what extent, assuming he is covered by a typical Blue Cross plan, are each of those person's expenses likely to be met in the longrun by Blue Cross coverage?

MR. WALSH: That is very difficult to say, because you don't know exactly what the course of treatment is. The plan held by the majority of people would cover at minimum 120 days of inpatient hospital care. All our coverages do provide for home care where the person is home-bound. Our coverages provide for nursing home care. This is the typcial Blue Cross coverage.

SENATOR HAMILTON: What part of home care or nursing home care?

MR. WALSH: I am going to consult with one of my experts in the back here.

SENATOR HAMILTON: Well, you can finish your other thought, if you want to.

MR. WALSH: Yes, I will. In addition to that, we do offer through group coverages now major medical, which would supplement the Blue Cross coverage and greatly enhance a person's coverage. There are many commercial major medical packages which are also purchased by people who have Blue Cross which would supplement our policies. For instance, the New Jersey State employees have Blue Cross and Blue Shield, but they have Prudential major medical on top of it. Major medical really is the type of insurance to cover the catastrophic condition that you have described. The basic coverage is if these types of illnesses were folded into them, it would be probably cost prohibitive. Major medical again, I believe that the majority of people in New Jersey do have some major medical coverage today. That is my understanding.

SENATOR HAMILTON: If you have any data that would substantiate that, I would like to see it. My uninformed impression would be to the contrary, but---

MR. LYON: We are working toward---

SENATOR HAMILTON: You want everybody to be enrolled in Blue Cross-Blue Shield, major medical. I understand that, Mr. Lyon.

MR. LYON: When the Insurance Department approves, we are going to file an individual major medical contract for non-group people. That will be a great bonus to the catastrophic victim.

SENATOR HAMILTON: Well, let me ask this: We still haven't reached the pocketbook, and I am sure that is the answer. You still haven't suggested a specific way in which government in action or government policy would encourage more people to get coverage through the private sector, whether it is the blues or someone else. Do you have any suggestion to that, since we said we were going to move in that direction, how we ought to move in that direction?

MR. WALSH: I will tell you, I really would like to share some of the input that you are going to be receiving for the rest of the day. I would be interested in hearing what some of the others have to say about this. At the moment I do not have a plan for that.

SENATOR HAMILTON: We would certainly be delighted to hear from you any observations you have about the work in the subcommittee as we continue.

Let me take the other side of it for a moment, because I have been talking with you about how we get greater coverage. Maybe this is a philosophical question. If so, treat me as a philosopher and give me an answer. Is it good - whatever that means - to have all or almost all of their medical expenses paid by someone other than themselves - directly paid by someone other than themselves?

MR. WALSH: You are asking if the provision of deductibles and co-insurances are a method of---

SENATOR HAMILTON: Socially desirable, either for cost containment coverage and informed of the health consuming public or otherwise.

MR. WALSH: There have been numerous studies pro and con - deductibles and co-insurance. Blue Cross has traditionally taken the position of first dollar payment offerings. We do offer coverages with deductibles, and the majority of the groups and the individuals opt for the first dollar payment. I myself feel that a provision of deductibles has a minimum effect on containing costs.

SENATOR HAMILTON: It would be suggested by Mr. Frankel wearing a different hat that a $200 threshhold is an incentive to shoot at and to use medical care. While I might disagree with his ultimate conclusion on what you do about that, I think I agree with him that that kind of a barrier is something that encourages the utilization of medical care, not in total disregard of its need, but with some indifference to the need. Perhaps that is something all of us can understand a little more readily. I don't know of an insurance company that offers first dollar coverage on collision.

It is a rare person, who, confronted with an $800 collision bill and a $200 deductible, isn't hoping that the body man at the end comes back and says I was able to do it for $600, and thereby not costing him his deductible. You may create problems like that. On the other hand, I wonder how informed a consumer is if somebody else is picking up the total tab. What you say to me is, what came first, the chicken or the egg, and we talked about that since the year one.

MR. WALSH: Right.

SENATOR HAMILTON: From your perspective and without having to come back and look, is there a significant difference in the coverages that are purchased by government - that is, where State government, or counties or municipalities are employers - from that which is purchased by private employers?

MR. WALSH: No, I don't believe there is a significant difference as far as Blue Cross coverages go.

SENATOR HAMILTON: How about Blue Shield.

MR. LYON: Basically the same answer.

SENATOR HAMILTON: Are there group plans where the group is a group of employees, but where the premiums are paid not by the employer, but by the labor organization to which they belong?

MR. WALSH: I am not certain. I believe there are labor unions who directly purchase care. They may be classified as associations, though, maybe.

MR. LYON: There are union welfare funds. I think that is what is meant by the question. They are administered by the union, and they buy Blue Cross and Blue Shield.

SENATOR HAMILTON: Is there a significant difference in those coverages from the others that are typically purchased?

MR. WALSH: No.

SENATOR HAMILTON: Okay. Mr. Walsh, if we might at some future time communicate with you for any further information that we hope you could offer us, we look forward to getting the information that is indicated. I am appreciative of what you have helped me learn here today, and hopefully everyone who is present here today.

I would have no further questions, but if you have any kind of general statement that you want to make, please feel free to do so.

MR. WALSH: No, other than we will be here for the duration. We are happy to participate. We will go back and I will let you know immediately whether there is going to be any difficulty in obtaining the data that you require. I thank the senior to my left for helping me through the Bornheimer bill. I apologize that I was not there in that era.

MR. LYON: You were fortunate.

SENATOR HAMILTON: Jeff, do you have anything further, or are you going to ride on what Mr. Walsh had to say?

MR. LYON: No, sir, we too will be happy to entertain any questions. I think most of your questions had to do with enrollment and rating and free handling which basically is done in tandem with Blue Cross and Blue Shield. But, we certainly applaud your inquiry and would be more than happy to cooperate and answer any specific questions you may have.

SENATOR HAMILTON: I am delighted to have your participation. I hope that we are all feeling as good about this six months from now. I know we are very hopeful about all this today, and I thank you very much.

MR. LYON: I think we set some kind of a record on S-446, didn't we? That went on for two or three years.

SENATOR HAMILTON: Well, I was only a part of it during the last year or so. But, I think besides the superb efforts of the sponsor, I have never seen a Chairman work a bill like Tony Scardino worked that bill.

MR. LYON: I couldn't agree with you more.

SENATOR HAMILTON: If we have made some mistakes, they were not mistakes from inattention or not caring, that is for sure.

MR. LYON: Thank you.

SENATOR HAMILTON: Thank you. Mr. Frankel, do you have any objection to taking Senator Dwyer's seat for a little bit and taking Mr. Melman with you?

J O S E P H F R A N K E L: Good morning, Mr. Chairman. I am Joseph Frankel, Assistant General Counsel of the Prudential Insurance Company of America. With me this morning is Richard Melman, Vice President and Actuary of the Prudential. You remember Mr. Melman who joined us during the debate on S-446, and I certainly

agree with your characterization of that bill. In the years that I have spent down here in the Legislature, I said it then, and I will say it again today, I don't think there was a finer piece of legislative work done, and this Committee is to be commended for it. Like the blues, we are happy to be here and to participate and answer any questions that you have. We don't have a prepared statement this morning, and I am glad we don't, because I think it would be much more helpful to try and deal with the questions that you have.

Either Mr. Melman or myself will try to answer your questions today. Mr. Melman is prepared to tell you about some of the things we do here in New Jersey. We have some written information that might be helpful to the Committee, and with that, I will be happy to answer any questions that you have.

SENATOR HAMILTON: Thank you very much. Of course, Joe, my acquaintance with you goes back a large number of years. My acquaintance with Mr. Melman goes back to S-446. I am delighted to have him here today. I think we could best proceed if we let Mr. Melman make his remarks and then the questions I have I will pose and whoever gets to the microphone first may answer the question for me.

R I C H A R D M E L M A N: If I can just make a few brief opening remarks, first of all, I have with me this morning a few copies of three publications of the Health Insurance Association of America. One of these is the annual source book which contains a wealth of information as to the number of people in the country with coverage, what type of coverage, the total for Blue Cross-Blue Shield, insurance companies, the public programs, medicare and medicaid and so forth.

In fact, this is hot off the press and has not been distributed to the many thousands of people in the country who are on the mailing list for you.

I also have a second book which shows the percentage, based on a one-day nationwide sample of medical charges which are paid by group insurance coverage.

And, the third booklet is a study of new policies issued to employers and shows the nature of the benefits that employers are purchasing today.

Now, it is rather difficult to get an accurate fix on just how many people in the country do and do not have coverage because of the overlapping and duplicate coverage problem that was referred to previously. But, the Congressional Budget Office estimates that between 11 million and 14 million people in the country have no coverage which is approximately 5% of the population, approximately 225 million people. So, I have no reason to believe that New Jersey is much different from this.

Approximately 95% of our population has something which is not to say that it is all good coverage. But, I am counting here medicare, medicaid, private insurance, the blues, HMO's, employer, self-insured plans and so forth.

Now, who are these people in the 5% who have nothing? They are principally four types of people. Number one are the poor who are excluded by the medicaid eligibility to which you referred earlier. These are people whose income does not meet the state standards or who perhaps are in categories of families such

as childless couples, or couples with children but where both parents are present, frequently excluded from eligibility.

The second group of people are the medically indigent. These are people who are above the poverty level but who are sharply notched out by the fact that if you go a dollar over the medicaid income limit you get no subsidy or help in buying coverage which is extremely expensive today as we all know. So, we visualize some kind of a sliding scale subsidy at the federal level in an ultimate NHI program as being the answer for those folks.

The third group of people are those people who are not eligible for group insurance because they are not in an employed group and cannot meet the standards of good health required to purchase an individual policy. In other words, they can afford it, but they can't get it. And, we do have in New Jersey a Blue Cross open enrollment period which makes coverage available to those people.

The fourth are people who are temporarily between jobs. For example, if a person terminates employment in one job his coverage may cease. It may be a while until he finds coverage with his new employment. We have children reaching the limiting age. We have widows and divorcees of employees who may lose coverage and so forth. While virtually all coverage today does provide a conversion provision, many people do not exercise it and are therefore deprived of coverage.

Now, I have talked about who has nothing. I would like to say just a few words about who has inadequate coverage. We visualize adequate coverage as consisting of high limit coverage, broad coverage with deductibles and co-insurance at the front end so as to retain a financial stake for the patient in the kind of care he gets. I am talking about a deductible, perhaps, of $100, or $300 or $500, whatever, commensurate with the person's income followed by co-insurance, but after the person has spent a substantial sum of money out of pocket that coverage would be 100% for the balance of the year. This, for example, is the only kind of individual policy coverage and the only kind of coverage that the Prudential sells to small employers. We have a choice of deductibles. We have 80-20 co-insurance. After the family has spent $1,000 out-of-pocket, it is 100% for the balance of the year and the maximum is unlimited, infinite, if you will. As you will see from one of these three books, approximately 90% of the private group insurance coverage being sold today has maximums of $1 million or more, and approximately 50% of the private coverage today has a maximum on the out of pocket that can be paid through co-insurance in a given year.

Now, there are in the population today 180 million people with private health insurance coverage. Of those, over 140 million have major medical. So, the inadequate coverage is composed largely of the people without major medical. Some of those policies are pretty good. For example, the United Auto Workers does not have major medical but has extremely broad basic coverage, which you might call catastrophic, although it is not major medical. So, I would estimate that of the $40 million people without major medical perhaps 20 million to 25 million people have inadequate coverage. Of the $140 million people with major medical, many of those folks have inadequate coverage because they don't have very large maximums or because they don't have a maximum on the out of pocket payment. If somebody is so unfortunate as to sustain a $200,000

bill, for example, even though the insurance pays 80%, 20% is a lot of money. Now, the public programs are also inadequate. Medicare, for example, does not cover prescription drugs. I think one of the problems that the Federal government must wrestle with, as they try to fill these gaps and allege part of the gap is in the public programs where coverage is extremely expensive in terms of tax money is, how are we going to pay for outpatient surgery under medicare, how are we going to pay for prescription drug coverage, and the long-term coverage is a very difficult issue, particularly with respect to the frail elderly. As you know, medicare is not providing a large amount of coverage in that area.

Thank you.

SENATOR HAMILTON: Thank you, Mr. Melman. You have addressed a couple of the questions I would have had, and you indicated that you have source material there in those publications that will undoubtedly answer some more. I know you have a limited number of copies. I would hope that you would favor the Committee with as many of those copies as possible.

MR. MELMAN: We have a half a dozen of each.

SENATOR HAMILTON: Fine. Thank you very much. Let me try to then cut short to some extent the questions I might have asked, but in large measure I want to go over the same ground I went over with Mr. Walsh and Mr. Lyon.

Who pays for the premiums, by and large, of the policies, and let's just talk about Prudential, because I know that your knowledge is more precise as to that. Who is paying the premiums on those policies in general terms?

MR. MELMAN: In most cases, the employer is paying the bulk of the premium. We do not have data on our own cases. But, I have seen studies that have been done by outside groups such as the U. S. Chamber, and a very large percentage of employers are paying the whole cost. I would guess that probably 90% of employers are paying at least 75% of the cost today, and probably more than 50% of large employers are paying the whole cost.

SENATOR HAMILTON: Those employers, what size are they?

MR. MELMAN: All size employers. Even on the small employers, I believe most of them are paying at least 75% of the cost.

SENATOR HAMILTON: Mr. Lyon gave us a number. I believe it was this typical group of 50 to 100 and the smallest group of 4 to 10. Can you give us any kind of comparable numbers with respect to your Prudential policies?

MR. MELMAN: Well, we write group policy holders to employers of as few as 2 employees. For those employers of 2 to 49 people we have this one policy available which I described to you. There is a choice of deductibles, but all of those policies are major medical, unlimited maximum, $1000 maximum co-pay in a given year.

From 50 employers up, the policies are tailor made to the employer's specifications.

SENATOR HAMILTON: How about for more basic coverage below the major medical, what are the size of the groups that you sell to?

MR. MELMAN: For coverage without major medical?

SENATOR HAMILTON: Yes, for coverages below the major medical range, or is major medical intended to be a first policy or an add on policy?

MR. MELMAN: There are such policies available through other insurance companies, but my company only writes major medical. In fact, we are writing a chevrolet and if you want to buy a buick, you buy from another insurance company. But, there are companies that sell basic. But, we only sell major medical below 50 lives.

SENATOR HAMILTON: I like people who use those terms. I usually understand them, but I missed. You are selling a chevrolet, and if we want a buick, we go to someone else?

MR. MELMAN: There are something like over 100 insurance companies licensed in the State of New Jersey.

SENATOR HAMILTON: Right.

MR. MELMAN: And, each of these companies files its forms and rates with the New Jersey Insurance Department. Now, my company has only filed and is only writing comprehensive major medical in the State of New Jersey. If somebody wants to buy a basic policy, an individual, without major medical, it is not available from the Prudential in this State.

SENATOR HAMILTON: I guess maybe I misunderstood. Maybe I show a bias for buicks. I thought what you were saying was you sell the chevrolet, and there is somebody who sells a buick which is a better car than chevrolet. We better define terms.

MR. MELMAN: Brand "A" or brand "B".

SENATOR HAMILTON: Okay, I apologize for misconstruing the entire thrust of what you were saying. I thought it was the kind of statement I would not have expected you to make unless it had some meaning, and I was looking for the wrong kind of meaning.

Do you have any age cross reference with respect to your policyholders, either with you or that you can speak of in general terms, or that could be made available to us?

MR. MELMAN: I have nothing with me. On our group business, we do not have age data, because we only get a census of the employee's age, never of the spouse or children. We only get a census where the group has not had previous coverage, which is the exception today.

Where the group has had previous coverage, or where the group has been in force with Prudential for a number of years, we do not get data. We rate that case on the basis of experience, and so forth.

Now, on individual policy coverage, we do have the age data on the people.

SENATOR HAMILTON: What proportion of your total policies are individual as opposed to group, in general terms? I don't need a precise number.

MR. MELMAN: I have some statistics here. Nationwide for the commercial insurance industry, approximately 85% of the coverage is group and approximately 15% is individual. Here in New Jersey, we have 46,000 people covered under individual policies, and 1,300,000 covered under group policies. However of that 1, 300,000 approximately 1 million are covered under the wrap-around major medical policies that Mr. Walsh talked about. So, that only 300,000 people have the full comprehensive coverage with Prudential on a group basis.

SENATOR HAMILTON: I want to get back to your statement about the need for some federal participation. But, before we get to that, I would like

your views as to the extent to which New Jersey in terms of general social policy, regulatory policy, tax policy or otherwise, encourages or does not encourage coverage and what you and I have both called adequate coverage and I suspect we mean something similar. What comments would you have? I am asking this of you or Mr. Frankel. I don't mean to have you and I monopolize this, but with respect to those policies.

MR. MELMAN: Well, as far as influencing the purchase of adequate coverage through the tax policy, I believe that the federal income tax has considerably more impact than the State income tax because of its much larger level. As you know, there are many proposals currently before the Congress, commonly labeled the pro-competition bills, which would put a ceiling on the deductibility of the employer contribution to health insurance. That is designed to cut down on the richness of the health insurance plan and to encourage greater use of deductibles and co-insurance rather than to upgrade the coverage, because most employers do have rather adequate coverage. The inadequate coverage is principally on the poor and the near poor who can't afford to buy good coverage.

Similarly, at the federal level the employer's contribution to health insurance is fully deductible. But, the individual's premium, either his contribution to the group or the individual who is not part of a group is only 50% deductible to a maximum of $150. And, the $150 doesn't go very far when medical expenses are as high as they are today. Good coverage costs a lot more than $150. So, I think we would like to see the federal government make the deductions for individual coverage more comparable with the deductions that employers enjoin.

SENATOR HAMILTON: It may be a side issue, but I am not certain it is a side issue. Do you have any insight into the historic reasons - when one stops to think about it, it seems like quite an anomaly - for why the employer can deduct and the individual can deduct half and only to a relatively low minimum?

MR. MELMAN: I do not. Of course, the individual can also deduct uncovered expenses beyond 3%. But, this number has not been changed in a great many years. Back in the '30's or 40's, or whenever that law went on the books, I don't know, perhaps $150 would do a pretty adequate job of buying health insurance in those days.

SENATOR HAMILTON: But, the individual can do that, regardless whether the employer has paid all of his premiums or he has bought it himself and only deducts half. That hardly puts him back in a position of parity. It just cushions the adverse impact with respect to the purchase price of the coverage.

MR. MELMAN: That is correct.

SENATOR HAMILTON: I suppose it is like a lot of things, it may not have been any kind of conscious decision. It may just have been the dynamics of the various pieces of legislation that came before the Congress. You are not suggesting that it is a result of any conscious policy to create that sort of an anomaly.

MR. MELMAN: I should clarify that I am not uttering official Prudential or insurance industry policy at this point. But, personally, I would like to see more parity between the individual and the deductibility for the employer.

SENATOR HAMILTON: How about in terms of state policy? Is there anything that is positive or negative with respect to the policies that we

have tax-wise, regulatory-wise, or otherwise?

MR. MELMAN: Well, we are talking big dollars. When you opened the session, Senator, you talked in terms of the gross national expenditures for health care which last year were $212 million, which on the population of 225 million people works out to be about $950 per capita. Most of the people who do not have coverage are the poor. So, if we are talking about expanding medicaid, we are talking about substantial federal and state dollars.

But, on the other hand, if we are trying to provide universal coverage, you can't very well leave the poor out.

SENATOR HAMILTON: Are you suggesting that the medically needy bill that has been around the Legislature if it is fiscally durable go a substantial part of the way to closing the gap as you described it in adequate coverage?

MR. MELMAN: Yes, I believe that goes a substantial part of the way. That still leaves the problem of the near poor who would be notched out at whatever the cutoff line was. As you know, the Senate Finance Committee last year in Washington in its discussions of catastrophic was talking about a sliding scale of subsidy for marginally employed people above the medicaid limit but not really up into the middle class or however you want to describe it. They were talking about a subsidy for people between the medicaid level and a family income of approximately $12,000.

SENATOR HAMILTON: You have expressed a preference for the use of deductibles and co-insurance. I assume both in terms of consumer consciousness and probably also in terms of total cost. I don't know. I am putting words in your mouth. Do you get that with the expansion of existing government programs, or do you get first dollar coverage?

MR. MELMAN: Well, medicare has both a hospital deductible in Part A, and a deductible in Part B for the professional services. Medicaid is a program for the poor people without resources. Personally, I believe there should be a deductible in there, but it should be scaled down commensurate with the reduced ability of those people to pay. But, I believe that "free" coverage is not good, even for people with limited resources.

SENATOR HAMILTON: Okay, in terms of talking about that co-insurance and recognizing that you have policies above, I think you said, 100 that are tailored to the particular person or entity that was purchasing the coverage, except in those tailored situations, are your co-insurance policies in any way income related, or is that just incidental.

MR. MELMAN: Some of our employers under their group insurance have purchased plans where the deductible is broadly income related. For example, the Prudential plan on its own employees has five brackets.

SENATOR HAMILTON: Five.

MR. MELMAN: Five income brackets, and the deductible ranges from somewhere in the neighborhood of $100 for the entry level young employee to $400 or thereabouts. Some of our employers have done that.

SENATOR HAMILTON: Is that an annual kind of co-insurance?

MR. MELMAN: No, that is the deductible.

SENATOR HAMILTON: How about on the co-insurance, is that income related at all?

MR. MELMAN: No, it is not. The co-insurance is 80-20 until you spend $1000 in co-insurance out of pocket, and then 100-0.

SENATOR HAMILTON: Without suggesting what Prudential ought to do, but only for my own knowledge, would the administrative complexities be too unweildy if you moved to, or if government moved to, some kind of reimbursement that with respect to co-insurance was income related?

MR. MELMAN: Well, bear in mind that we are talking about an employer here, and we are only talking about wages of that employee. We are not talking about family income, or that sort of thing, so the employer has his payroll records, and he knows that this person is a $10,000 a year or $20,000 a year person. But, it is not as we find and precise as, for example, if the new file clerk is the daughter of a millionaire, she gets the small deductible because her wages are low.

You might be interested to know that under our individual policies there is a choice of deductibles. You can buy a deductible anywhere from $100 to $1000. You hear a lot of talk which I characterize as cocktail party coversation, as to why don't insurance companies sell $5,000 deductibles, because I am pretty well off, and I could afford to carry the first $5,000 myself. What I really want is coverage for the catastrohpic. So, as a result of this, we recently came out with the $1,000 deductible. Prior to that we had $100, $300, $500.

SENATOR HAMILTON: What are the more popular?

MR. MELMAN: I believe this conversation is limited to the cocktail parties, because nobody buys it.

SENATOR HAMILTON: You are not selling any $1,000 deductible.

MR. MELMAN: People want coverage. Ninety percent of the people are buying the $100 policy.

SENATOR HAMILTON: And, these are people who are purchasing individual policies?

MR. MELMAN: Individual policies, right.

SENATOR HAMILTON: You are also going to be dealing, by and large, with the 20% most affluent people in the particular population that you are selling to, I would think; is that correct?

MR. MELMAN: I don't believe so. Of course, our kind of policy is purchased by people who can afford to purchase comprehensive insurance, but if you look at the people who are buying medicare supplements, for example, these are certainly not people in high tax brackets. They are paying for that with their own money, and they want to buy first dollar coverage.

SENATOR HAMILTON: What I have gathered you have said, as long as it is limited to individual employees for the policyholder, the administrative complexities of relating the co-insurance to income are not monumental.

If you had to take into account instead, total family income, and not the employee, in the case of Prudential's own people, or the policyholder in the case of individually purchased policies, the problem would become more difficult, at least for Prudential to run a program.

MR. MELMAN: Well, this would be extremely difficult because you are now into some sort of honor system, and perhaps after the fact verification with IRS which is a whole additional step to the process.

SENATOR HAMILTON: Well, in probably much simpler terms, the State does something like that in terms of the pharmaceutical assistance program.

MR. MELMAN: Yes.

SENATOR HAMILTON: You come in with last year's tax return which

is family income. It is a single person or a husband and wife, because we are talking about seniors, and it is in a sense income related. At least you see wh.. the income was for the preceding year. I am not suggesting that would be an easy task for a private insurance company such as Prudential, but that it perhaps will be durable to the extent that you are talking about some kind of governmental subsidy or the unusual cost, it could be income related in some fashion.

MR. MELMAN: We did find at the federal level in the discussions of the catastrophic that the Committee wished to base it on both the income of the prior year or the expected income of the current year if significantly lower. So that if, for example, a person lost his job and was unemployed, he would get the benefit of the treatment applicable to the lower income.

SENATOR HAMILTON: So, to that extent the only place which you call the honor system would come into play would be the significantly lower current year as contrasted with the preceding year which ought to be a matter of record.

MR. MELMAN: Right.

SENATOR HAMILTON: Do you care to comment about the impact --- Let me ask you first, which may be a more factual question, what is your understanding concerning the standards authorized, at least, by the Bornheimer legislation as to whether or not they are presently in effect or whether they are in abeyance?

MR. FRANKEL: There seems to be some confusion on that, Senator. In fact, I was discussing it with Laurine Purola the Insurance Committee Aide when Mr. Walsh and Mr. Lyon were testifying. I diligently searched through the legislative news sheets to find out whether that had been received by both houses of the Legislature as it had to be, and I could not find any reference to it. Laurine is under the impression that it was received, and I would like to clear that up, because the time frame for implementation is important as to whether it starts from September 22, or whether it started at the end of July. So, I think it is in a gray area right now. I am hard pressed to answer that question.

SENATOR HAMILTON: Then any further questions along this line, your answers would have to be tentative in perspective. But, as presently either proposed or on line, do those regulations as they are pose any serious problems either for Prudential or the private insurance industry generally?

MR. FRANKEL: No, originally there were some problems with their regulations. We commented at the Bornheimer Committee hearing. They went back to the Insurance Department. There were some changes made and we can live with those regulations. I think we have some representatives here from the Health Insurance Association of America, and correct me, John, if I am wrong, but I think that follows for the rest of the industry also; isn't that true?

MEMBER OF AUDIENCE: That's correct.

SENATOR HAMILTON: Again, it is not directly germane, but there was reference earlier to S-419. I don't know whether you want to comment on that at all or not, because I am not aware that it has been re-introduced. If you do, give me some insight as to the kinds of problems that were created, not without a specific discussion of the legislation.

MR. FRANKEL: Well, we were opposed to S-419 in its original form.

We feel there is adequate regulation of the private insurance industry now in New Jersey. The Insurance Department has always diligently policed the practices of the private industry. We saw no need for the bill. We were happy that the bill was amended and signed into law without those provisions. There were changes made in the bill that I think, as Mr. Lyon said, gave greater flexibility to the blues. So, we are glad that is the way it ended. We would have a problem with that bill. As I say, we feel we are adequately policed at this time.

SENATOR HAMILTON: Do you think the Bornheimer bill is an adequate substitute for the purpose, if not the language, of S-419 as it originally came before the Legislature?

MR. FRANKEL: Yes.

SENATOR HAMILTON: Mr. Melman addressed himself to the meaning of adequate, and I won't ask him to repeat that. I think you have also covered everything I would have asked about the gaps in coverage. You point primarily to certain income groups and to a limited extent to some of the major medical coverages, as I understand it.

MR. FRANKEL: I would just like to go back, Senator, to the co-insurance feature and about Prudential and its own employees and wondering if there were some changes made. Remember, now, we have employees all over the country. What happens in New Jersey to employees of our company--- and I am sure to many companies who are here, but remember they are in other states, so that could impact employee benefits and so forth in all the states, whereas the laws of other states may not deal with that particular issue. I don't know how that fits into your thinking about changes. But, keep in mind we are not solely a New Jersey corporation.

SENATOR HAMILTON: I suppose that comes into it in context with the question I posed to Joe Walsh. If there were a limitation, for instance, on the deductibility of premiums as against the corporation business tax that might otherwise be due and owing, and you have a multi-state employer such as the Prudential - that the deductibility is geared to meeting some standard of adequate coverage, whatever that may be, does that pose severe administrative problems in terms of payroll and otherwise?

MR. FRANKEL: I don't know. Do you know, Dick? Would you want to venture an answer.

MR. MELMAN: I can't answer that, Senator. It sounds like it might.

SENATOR HAMILTON: Well, I would suspect that if anybody is going to give their own employees adequate medical coverage, I would assume it would be an insurance company like the Prudential.

Of course, you probably ought to go to somebody who makes widgets, or something of that kind, rather than somebody who sells health insurance.

MR. MELMAN: I think we would hate to see this mandated, and we would prefer to leave it to enlighten the employer to try to work it out. I am also conscious of the fact that while we are talking about stimulating minimums here that the federal government is talking about stimulating and depressing the maximum. So, hopefully we will not get into a squeeze where we are being pushed in both directions.

SENATOR HAMILTON: Well, you have made some observations about the desirability of some federal action and also about the pendency of certain

bills that I did not detect that you necessarily commented on favorably. What is your prognosis for meaningful federal action?

MR. MELMAN: Well, I believe that the thing that is holding national health insurance back is the tremendous cost to the taxpayer of filling in the gaps in medicare and medicaid. I believe it is coming, but with budgetary constraints. Everything you read from Washington seems to be that it will be a matter of several years and well into the decade.

As far as the pro-competition bills go, and there are a number of these bills--- As you know there have been bills introduced by Congressmen Allman, Stockman, Graham and Senator Durenberger, and Senator Schwiekert, and Congressman Jones, and there have been quite a few.

The concept is very good, and in principle they are very good, but to make them work in the real world is going to be rather difficult. For example, if you just put a ceiling on the amount that an employer can contribute to health insurance, regardless of where the employer is, there are a lot of people who happen to be employed in Los Angeles and New York and New Jersey and Chicago and places where health insurance costs are high, and if you are so fortunate as to work in Arkansas or Tennessee or somewhere where the costs are not so high, then the tax burden is going to fall unevenly.

Also, if you talk in terms of giving a cash rebate to the employee who elects the more modest insurance plan, this is one of the features of the bill, to encourage people to be more cost aware of medical costs by electing a more modest plan. We know that medical care costs vary greatly by age, and you can't simply put in a flat rebate which is the same for the nineteen year old as for the sixty-four year old, because the nineteen year olds will all elect the cash based on what the value is to the older person, and so forth, so to make them work is going to be pretty complex.

SENATOR HAMILTON: Well, in part you have given flesh to bones that I brought up before about some of the problems that I saw, assuming it was solely a federal problem. But, you have also made an assumption that I am more familiar with those pro-competition bills than I am, and if it is not a great burden on you, I would appreciate you letting Mrs. Seel have a copy of those bills, because while I am generally familiar with the Kennedy and Carter proposals for national health insurance and so forth, I was not aware in any kind of detail at all about those other bills, and I would like to be before we complete the work of the subcommittee.

MR. MELMAN: Fine.

SENATOR HAMILTON: I recognize what you said about federal action, and I heard clearly what you said about not having anything mandated in terms of meeting the certain standard, and it would be deductible. If your prognosis is correct about the timetable for federal action; if the other things that you said about the problems of legislating nationally for situations that differ in 50 states with different costs of living and so forth, other than filling in the medically needy area, do you see a role--- Would you come before us today and say go ahead with respect to some kind of state activity, be it regulatory, statutory or new programs?

MR. MELMAN: Well, the position of our trade association and of the Prudential is that these gaps are best addressed at the federal level and in terms of the four gaps we are talking about reform of medicare and medicaid,

a partial federal subsidy for the near poor, and legislation that would address the two gaps in what we hope will be retained as the private insurance system, namely, all those who are neither poor nor elderly. We would welcome legislation at the federal level which would do two things: First of all, it would only give the tax deduction to contributions to insurance plans that bridge the gap of this temporary discontinuance for people between jobs, for widows, divorcees, children reaching the limiting age, et cetera; secondly, legislation that would require all carriers, and that includes blues, insurance companies, self-insuring employers, HMO's, everybody, to share in the cost of providing insurance at reasonable cost to the people who are uninsureable or high risk. In effect, if you will, it would be kind of an industry-wide pool for the present open enrollment.

SENATOR HAMILTON: A kind of fare plan.

MR. MELMAN: If you try to relate this to the state level, I believe the fourth one might make some sense, and in fact, Connecticut and Minnesota now have such laws on the books. Every insurer is required to offer a plan of adequate insurance - this is major medical unlimited, $1,000 out of pocket, choice of deductibles - to any individual regardless of the state of his health, and the losses of that pool are spread over all insurers.

SENATOR HAMILTON: How do you respond to that Minnesota and Connecticut legislation? Is that something, not necessarily that you embrace here today, from your point of view that should be seriously considered by the State of New Jersey?

MR. MELMAN: We like the Connecticut program in particular. There are features of the Minnesota plan we do not. But, I believe that we would certainly not oppose a bill like the Connecticut bill in New Jersey, which would help to fill this one gap.

SENATOR HAMILTON: I do have some information on the Connecticut and Minnesota plans as they operate. I think I should become more familiar with it, and I think my colleagues should become more familiar with it.

I assume that the Minnesota legislation at least in part stems from some proposals by a former speaker now Congressman Szabo of Minnesota.

MR. MELMAN: I do not know.

SENATOR HAMILTON: One final area, you indicated your belief based upon the statistics that you have in your own experience that we have about 95% coverage in terms of costs, and we have maybe 5% of the population generally poor and perhaps frequently elderly, although that may not be the case, that is without any coverage. Accepting those figures fully, at least for the moment for this question, given that, how do you account for the plight that I am told and my colleagues are told many of our urban hospitals in this state, one of the two or three wealthiest states in the nation, find themselves with the possibility of shut down more than theoretical. It is a very real possibility.

MR. MELMAN: Well, S-446 goes a long way toward remedying this problem, because as you know, prior to the passage of this law medicare, medicaid and Blue Cross paid for the cost of treating their own patients and did not pay for the cost of the no-pay patients. That cost was borne solely by people

with commercial insurance or self-pay or employer or union self-insured plans or whatever, so that if in Newark, let's say, 5% of the patients have no coverage, and cannot pay, those costs were being borne by perhaps 10% of the patients, since 85% of the patients have medicare, medicaid or Blue Cross.

That load is now being spread over the 95% of the paying patients, which is very good, and will help to spread this load. But, in New York City, the old situation still applies, and they only have 4% of the patients in New York who pay on the charges basis. 96% of the paying patients pay only their own costs and so the 4% cannot pay for the no pays. That is why the New York hospitals are going broke.

SENATOR HAMILTON: You are suggesting that in New Jersey when S-446 has a longer time to function that the plight of the urban hospitals is going to be substantially diminished, and isn't going to be nearly as acute as it is right now, or as it has been until right now.

MR. MELMAN: I would hope so, but the way the urban hospitals are being reimbursed under S-446 is through a subsidy by all the paying patients, rather than being reimbursed for the non-paying patients. Another way of doing it would be to extend medicaid and have the taxpayers pay the cost of providing hospital care to the poor rather than having the insured population pay the cost of providing---

SENATOR HAMILTON: I made that observation while the bill was under consideration. It was undoubtedly an indirect tax on those people who were within the population that were making that subsidy. Before we are finished, a major consideration of this subcommittee would be how much this would cost us if we extend medicaid to the medically needy and how much can you buy for 75% of that, how much can you buy for 50% of that, and what are we going to be able to get, and where are you going to be able to get it? Certainly, you have made some suggestions and perhaps at some later time I would like to explore them with you in more detail when we are discussing Minnesota and Connecticut and your aspirations for some federal legislation.

I have no further questions at this time. I appreciate your participation. I appreciate the fact that Mr. Frankel is here with you, and I am sure we will see much more of him. If there is anything more you would like to add by way of a general wrap up, I would be happy to hear it.

MR. FRANKEL: I would just like to say this, Senator, not only at these hearings, but at any time, if the Committee feels we can provide any data or any assistance, we would be more than happy to do it. There may be questions that come up, and I hope Eleanor feels free to give us a call, and we will be happy to cooperate any way we can.

SENATOR HAMILTON: Thank you both very much. I would like to at this point stretch for about five minutes, not any longer. I would like to proceed with Mr. Price from the Department of Labor and Industry and then Mr. Nimmer and Mr. Cottingham who I believe are citizens and not associated with any organization. I would like to proceed at least with those persons and then see where we are with respect to a break for lunch.

It is now about 12:28. If we can reconvene at twenty-five minutes of, that is seven minutes for a break. Thank you.

(Whereupon a short recess was taken.)

AFTER BREAK

SENATOR HAMILTON: We ran through the break by taking an extra 12 minutes longer than we intended to, but I don't see anybody who is complaining about having a longer time to stretch. I won't set a firm deadline for lunch, but somewhere in the area of 1:30, give or take, would make the most sense.

I do want to proceed with some of the other persons who indicated they wanted to participate today. Mr. Robert Nimmer signed up to speak, but I have been lead to believe that Mr. Nimmer may have had to depart to take care of other matters. Is Mr. Nimmer present? (no response) If not, Mr. Jim Cottingham, who I believe is here solely in his own behalf, can introduce himself and tell us where he is from. We would then be happy to hear his remarks. Mr. Cottingham.

J A M E S C O T T I N G H A M: Thank you very much, Senator. My name is James Cottingham. I am employed by Burlington County College in New Jersey, down in Pemberton. I formerly was a lobbyist on behalf of the county colleges. Unfortunately, because of my accident I am not in that position any more, but I do want to make it clear that I am speaking solely as a private citizen and an individual, and I am not representing any other group.

Last November I had an accident while I was helping my in-laws, which resulted in a fractured spine and a fracutre femur. I was treated initially at a New Jersey hospital and later transferred to New York University Medical Center, and to numerous other hospitals after that. I have spent six of the last nine months in and out of five hospitals. During that time, I have learned more than I ever cared to know about hospitals and about health insurance plans.

In January, after I recouperated somewhat from the fractured back and the fractured spine, I was preparing to be discharged by New York University Medical Center. As a public employee, I am insured through the State Health Benefits Commission for my health insurance coverage. Specifically, my coverage comes through the Health Care Plan of New Jersey, Federally-chartered HMO, which operates in conjunction with Prudential Insurance Company as their underwriter and guarantor.

I told my health insurance company that NYU would be ready to discharge me in early February and that I needed to go to a rehabiliation center. Just to give you some idea of why I had to go to a rehabiliation center, many people think that a paraplegic's problem is that he can't walk. That is a minor inconvenience to a paraplegic. The paraplegic's real problem is that he can't control his bowels. He can't control his stools. He can't control his bladder function. At that time I had a catheter inserted in me to drain my bladder on a continual basis and nurses had to medicate me and manually remove stool on a daily basis. There was no way that I could be discharged to my home. There was no way at that point that I could ever have gone back to work.

My health insurance company, despite what I read as coverage for this type of a case, said, "No, we are sorry; we do not provide any coverage for rehabilitation services." At my request, they put that in writing, and I have the letter.

I was extremely emotional at that point. My life was dedicated to my work and to my family. The only alternative they could suggest was that I go to a nursing home. They do provide some coverage - the gentleman from Blue Cross, Blue Shield indicated this - for nursing home care. This is pretty much standard to the State Health Benefit contract. But, Blue Cross, Blue Shield, and the HMO's do not have any coverage in their basic plans for rehabilitation. I think

this goes beyond the State Health Benefits Program to include other contracts, although I am not sure of that. They are supposed to include coverage under the Major Medical plans, which are underwritten by Prudential, but in this case they were denying me the benefits. I didn't know what to do. I laid in bed and I cried. I cried for two days because I didn't know what I was going to do. I had to get out of the hospital. The hospitals are acute care facilities. They cannot keep you there once you no longer need their acute care service. This is in order to contain hospital costs. I didn't want to go to a nursing home. I am only 36 years old, and I couldn't see spending the rest of my life in a nursing home.

Fortunately, a social worker there mentioned to me the fact that New Jersey has a vocational rehabilitation services program that operates through the Department of Labor and Industry. I contacted them. Believe me, people sometimes complain about state government, but those people are fantastic. They arranged for me to go to a rehabilitation center in Philadelphia that specialized in spinal cord injury victims. There was a co-payment basis, but the vocational rehab program operates through Social Security, and after reviewing all of my financial records,they were able to make it something that I could afford. We had $3,000 in that bank at that time. The rehab hospital cost $300 a day, and if it weren't for the Vocational Rehabilitation Program, I could have spent 10 days in the hospital when I knew I needed closer to three months. Eventually, I was fortunate to get out in eleven weeks.

During that process-- I am a funny guy; I am not going to let somebody off the hook when I think I am entitled to something that I have paid for. And, incidentaly, people do pay extra in order to get HMO coverage in the State Health Benefits Plan. So, I filed a complaint with the Division of Pensions, with the assistance of people from the college and the college attorney. It outlined why I thought there should be coverage. Mr. Joseph and Mr. Mount from the Division of Pensions, and members of the State Health Benefits Commission were very, very helpful. They agreed that there should be coverage. They contacted the Health Care Plan of New Jersey and summoned them to appear at a Health Benefits Commission meeting. They still denied that they should provide any coverage for rehabilitation and physical therapy.

In the end, the State Health Benefits Commission had to order them to pay or else they were going to take action in 10 days to-- I am not sure what they were going to do, whether they were going to terminate connection with Health Care Plan or withhold the payments and pay them directly. I am not certain. I found recently, though, that I may have won the battle and lost the war, because while they are paying for those expenses, in the State Health Benefits contract under the Major Medical Plan as it now exists, there is a maximum benefit of $25,000 that can be paid in any one year. My bills at the Rehabilitation Hospital come to $22,000, plus. My medications and medical supplies for these problems I described before cost me about $500 a month since I have been discharged from the hospital. Those are subject to the 80% reimbursement under that Major Medical plan. Obviously, I am going to go beyond that $25,000 per year.

In addition, during July I had some unexpected medical complications and had to go back into the hospital. I am not going to make it on $25,000 this year. I don't know how I am going to pay the difference. Further compounding this is the fact that I am, as I mentioned, 36 years old. I am going to be

spending at least $500 a month, the way it looks, for the rest of my life, and the State Health Benefits Program says that the maximum an individual can receive over their lifetime is $100,000 under the Major Medical Plan. But, they do make adjustments, where once you hit the maximum they restore $2,000 a year. But, that is minimal. It is going to be inadequate for me.

I have a colleague at the college, who has a son that broke his neck four years ago. He had the Blue Cross, Blue Shield Plan, and Prudential Major Medical, the other aspect of the State Health Benefits Program. I guess it is called the traditional program. He found that the first year, right away, he hit the $25,000 maximum and had to then absorb the other expenses himself. You know, you get into a situation of pleading with the hospitals to forgive parts of the bill, and with the doctors to let you off the hook on some of their charges, or keep them under the level. I have a shoe box at home where I keep the bills I try not to think about.

It is a problem which needs to be addressed. It is not a problem of one individual. It is a problem with many people in the State Health Benefits Program. We have three people connected with our college. We are one of the smaller colleges in the State who have a problem.

Bob Nimmer is fortunate in a way. His son has graduated from high school now and was able to qualify through the Medicaid Program and go off of his dad's State Health Benefits Program, just as he was hitting that $100,000 maximum which would have put everything on the family from here on out.

Allan Penn, who recently enrolled at our college, broke his neck in a football game last year. His dad works for the State Civil Rights Division. Allan's problems are just beginning, and his partents' problems are just beginning. But, I know that his bills have been absolutely astronomical already. He is a quadriplegic. He has very little motion below the neck.

If in one small area of the State, with a relatively small number of public employees, you find these many problems, I think you are going to find that statewide there are quite a number of people who have problems, and maybe it is time to relook at the State Health Benefits Program. Maybe it is time we took a fresh look, as the Senator suggested, at all health insurance coverage.

On the basis of my experience, I would like to make a few suggestions about problem areas, or places, where we might start, that I think are more general than just the case of Jim Cottingham. One is, I think we need to take a look at including rehabilitation services as something that is included in the basic Health Benefits Program that all of the carriers offer. When people have a serious problem, whether it is an amputation, a stroke, or a paraplegic, rehabilitation is not a luxury; it is a necessity if the person is to become an independent human being, able to function at home, if not go back to work.

More specifically with the State Health Benefits Program, I would like to suggest that maybe it is appropriate, in view of rising health care costs, that the $25,000 per year ceiling either be eliminated, or at least increased. Also, the lifetime limit of $100,000 needs to be increased. I think these limits were set some time ago and maybe in view of rising health care costs it is time we look at them again.

I am aware that you are already attuned to this problem, Senator Hamilton, and you are trying to do something in that regard. Anything you could do would

be most appreciated by the people who have through no planning on their own part - we certainly could have planned it better - wound up hitting up against the ceiling. That is all I have to say. I would be happy to answer any questions you might have.

SENATOR HAMILTON: Mr. Cottingham, I don't know that anyone could really ask you any questions. Certainly, the fact that you have been willing to come here and tell us of some very personal experiences and some very tragic experiences speaks very loudly about your concern not only for yourself but for other people who may find themselves in a similar situation.

I would like to ask you one question, and then maybe I would like to explore one or two other things. The denial of benefits under your Major Medical was articulated as being based upon just what? I missed that in your presentation.

MR. COTTINGHAM: In the HMO contract with the State of New Jersey, it has two parts to the plan. The basic benefits, which they call their Basic Plan, and the Major Medical or supplemental benefits. In the Basic Plan, there is an exclusion rehabilitation. The HMO was trying to maintain that exclusion by not only the Basic Benefits but also to the Major Medical benefits. When the State Health Benefits Commission told them they were not accurate -- they used a few more graphic words than that -- they then resorted to trying to use other things. They said in that event they would only pay for rehabilitation if it were a licensed hospital, certified by the Joint Commission on the Accreditation of Hospitals, and they wouldn't pay for any rehabilitation centers. Well, it so happened that the hospital that I was sent to, the Memorial Hospital in Philadelphia, is licensed by the Joint Commission on the Accreditation of Hospitals. So, they lost on that. They tried other ways to avoid paying for it also.

I know that $20,000 is a lot of money, but I think that we need to write the policies pretty specifically, to mention that rehabiltiation is included even in the Major Medical Program that Prudential has for state employees enrolled in the Divisional State Health Benefits Program through Blue Cross, Blue Shield. Rehabilitation is included in that program by the fact that it isn't excluded. It is not mentioned specifically as one of the things that is included.

The reason why I decided to come here today was, in trying to work things out with my HMO carrier I happened to talk with one of the subordinates the other day and she hadn't yet heard about what happened to me, and that I won the case through the Division of Pensions. She conceded, "Gee, there are a lot of other people who were public employees and who were denied the benefits. We never had to pay to them." In fact, there are people since my case who are being denied benefits and who don't know the people to contact in Trenton in order to get the situation resolved. I think that is something where the health insurance companies are in business to provide health care, but they are also in business to make money, or to break even. If they think they can avoid paying for something, I think they will try to avoid payment. I am sorry, but that is the way it struck me, at least from my experience with the health insurance carriers.

SENATOR HAMILTON: Jim, I haven't met you before today. I have known of situations like your own. I know it is of no solace to you that you know of other situations where the injury comes from either a sport or a liesure time activity, many of which do not involve a plan with even the limits that are provided by this State Health Plan, and that creates an even more tragic situation than

your own.

You have alluded to S-1483, which I think has reasonable prospects of moving through at least one House very early in the fall. As you testified, it occurred to me that in that legislation we change the lifetime maximum, or we propose to change the lifetime maximum, and we propose to change the yearly maximum that is authorized. Your experience, as you have described it to me and as I think upon it, and probably the experience in a lot of other cases, probably dictates not necessarily that the yearly maximum change but that the first annual maximum be increased. Probably, in most cases, the maximum of expenditure is going to be in that first year. Would you agree with that?

MR. COTTINGHAM: I would think that in the overwhelming majority of the cases the first year is certainly the worst year. There were some people I met in the rehabilitation hospital who had been out for five or six years with their injury and who ran into serious complications at home. It is very difficult to take care of a quadriplegic at home. This particularly refers to fellows who are quadriplegic. In addition to some of the other problems I mentioned before, you run into what they call decubitus ulcers, or bed sores. Because most people who have a spinal cord injury have no feeling in the lower part of their body, or in some cases have no feeling below the neck, they do not know when they are having too much pressure put on a part of their body. They cannot turn themselves. Someone must move them around every two hours.

I met some people in the hospital. You know, after they are out a few years, it just got to be too much for their parents to get up every two hours at night and so they developed ulcers. In one case, the gentleman's ulcer covered his whole hip area. The skin had deteriorated. You could see his hip bone. Osteomyelitis set in. In the overwhelming majority of the cases, you are right; the first year is the most critical. But, there are people whose problems may become even greater in subsequent years.

I think you also run into problems with kidney dialysis patients, were it is very rough initially, but it can get even worse. So, if it is at all possible, it would be good if it could be increased just to help that small number of people who are unfortunate enough to have more serious problems later on.

SENATOR HAMILTON: You have certainly helped to focus our attention on the problem in a very personal way. There is a great irony, where had you been involved in an automobile accident, the problems that you have had - although you might have had some - might have been on a far different scale than they are because of it apparently being an accident in the home, not work related and not related to an automobile.

MR. COTTINGHAM: One of the standing jokes in the rehab hospital was, "If you are going to go out and break your back, do it in a car accident." Because of no-fault insurance right now, there were four or five people in the hospital with me who had been injured in automobile accidents and they had no problems. All of their rehabilitation was paid for by the insurance company. They were helping with home renovations. They helped them with mony in lieu of their salary. I think no-fault insurance, for whatever problems it has, has really gone a long way towards helping people who have a major injury. Some of them commented that years ago most of them were not responsible for the accident; it was someone else. But, the most they could have hoped for was to get $20,000 or $50,000 worth of medical coverage. One of the gentlemen who I am particularly friendly

with was paid over $200,000 last year by his no-fault insurance company towards his care.

SENATOR HAMILTON: There is no doubt that in terms of social policy, all reasonable and medical expense - I guess that is the way it is worded - by inclusion rather than exclusion is fine social policy. I had personal experience with a client on whose behalf the carrier paid out in excess of $170,000. He is a quadriplegic, and he happened to be a passenger and clearly not at fault in the accident.

Obviously, you have a great interest in this, not only on your own behalf but also because of others. I would hope that we have your address and that we might, if the occasion becomes necessary, communicate with your further for any insight or any comments that you may have.

MR. COTTINGHAM: Senator, I would appreciate it if you would get in touch with me again if I can help. I think all of us, when we have a major accident such as this, try to find some reason for it, and as I pondered on it over the months in the hospital, I decided that maybe God was trying to lead me to use some of the skills that I had to help other handicapped people. As I mentioned, I had been a lobbyist before, and while I will probably not be formally representing any groups in the future, on a informal basis I would hope that I will be able to take an active role in the State House in supporting legislation that will benefit all people who have serious disabilities and problems. I certainly look forward to working with you and with your Committee.

SENATOR HAMILTON: Jim, that is really great. I don't think any of us who have heard you today will have to worry about what is going to happen to Jim Cottingham. You are going to have your problems, but you are going to cope with them. I appreciate, and I am sure everyone here appreciates, you being here and sharing with us your experience. Thank you very much.

MR. COTTINGHAM: Thank you very much, Senator.

SENATOR HAMILTON: I have at least one representative of the New Jersey Federation of Senior Citizens. I have the names of Mr. John Kelly and Mr. Andy Gottberg. I don't know whether they are together, nor which is going to testify -- or whether you are both going to come forward. I would like to welcome both of you gentlemen on behalf of the Federation of Senior Citizens, who have certainly found their way to Trenton within the past few years and who have given us a lot of insight on a lot of problems. I hope you are going to do the same today.
A N T H O N Y J. G O T T B E R G: I would like to thank you, Senator Hemilton, for listening to us today. I am Anthony J. Gottberg. I am President of the Senior Citizen clubs of Bergen County. I am a member of the Bergen-Passaic Health System Agency. And, I am on the Executive Board of the New Jersey Federation of Senior Citizens.

In the last two years, one of the concerns of the Federation has been the under-reimbursement by Medicare of the physicians' fees. At the present time in New Jersey, less than 50% of the actual cost to beneficiaries for doctors' fees are reimbursed by Medicare. While we do not believe it was the intent of Congress in 1964 to pay the total cost of seniors' health care, it is felt that a reasonable reimbursement by Medicare would be 80% of the fees paid by the senior citizens to the physician.

Our Committee finally agreed that improvements should be made in the following areas: 1. Prudential -- the carrier; 2. Rewording of the law;

and, 3. The medical profession. When the medical insurance claim is submitted, the carrier compares the actual charge shown on the claim with the customary and the prevailing charge for the service. The carrier then approves whichever charge is the lowest. It then pays 80% of the lowest charge. That is going down gradually until it reaches the bottom line.

To explain more clearly, at the present time the amount paid by the average beneficiary is 80% of an approved amount, not 80% of the amount billed. An example - and I have given to another group of Congressman, up in Bergen County, some 300 or 400 of what is called "EOMB's", which gives the senior an idea of what he is getting, and I have an EOMB here - if an office visit costs the senior $30, the amount approved would be $14.30, and the amount payable would be 80% of the $14.30, or $11.44. In other words, this EOMB I have here is a $40 bill, of which the man received $11.44. The cost to the seniors before they received this $11.44 for the first time must also be noted. Medicare costs us $9.60 per month, and $115.20 per year, plus a $60 deductible. I notice the deductible was mentioned here previously. The total that we pay is $175.20 per year before we, as a beneficiary, receive any reimbursement. A $40.00 bill -- $11.00.

The imposition of the economic index and the formula in Title 42 states, very clearly, that it does not limit the amount a doctor may charge a patient; it only limits the amount Medicare pays a patient. That is what they call cost containment, but it is not cost containment as far as we are concerned; we pay the difference, regardless of what it is. And, it is obviously one-sided.

In addition, the statute does not sufficiently take into consideration the higher cost of living in the metropolitan areas of states like New Jersey. That would, of course, include the metropolitan area of Bergen County, which is within shouting distance of New York City.

Another major cause of the reimbursement problem in New Jersey was the redistricting of the State from its original eight localities. One of the eight localities was eastern Bergen County. The county is a high-cost-of-living region in the New York metropolitan area, as I have mentioned. In 1974, the Prudential and the Social Security Administration redistricted New Jersey from eight to three localities. Bergen County was at that point absorbed into the eleven northern counties. Cutting the districts from eight to three localities may be considered efficient, but to the seniors it was anything but financially helpful. It was found that we were paying a much larger percentage of our health costs. The bottom line, again, the doctor's charge for a house call, $30.00; payment to the patient, $11.44. And, you might note that if the charge by the doctor is $25.00, you get $11.44. If the charge is $30.00, you get $11.44 for a house call. If the charge is, as in the instance I have here, $40.00, you get $11.44. So, regardless of the charges a physician might make, as the years go by and he feels he needs more, the payment to the beneficiary, the payment to the senior citizen, is approximately the same. It goes up a little -- like 80¢ a year. Marvelous.

At present, there are few physicians willing to accept assignment, and we would appreciate it if more physicians would reevaluate their position and accept Medicare reimbursements. And, another thing, physicians should more clearly indicate, on Medicare forms, the services rendered to the patient. It is quite possible that in some of these cases where you get a $40.00 or a $50.00 bill, a number of things have been done to you, such as blood pressure and other

items that have to do with your health care. But, if the nurse, in getting through with the case, says nothing more than "service", or nothing more than "office visit" $40.00, we are going to get payment as if it were a $15.00 or a $20.00 bill, where we get only our $11.00. So, the physician should more clearly indicate on the Medicare forms the services rendered to the patient.

In conclusion, we feel that Medicare B needs improvement in order to reverse a trend we have been observing among the elderly -- and this is so important, and it is heart rendering. It is characterized by a self-denial of entitled benefits because of low Medicare reimbursement. If a person knows they are going to their doctor and get a $30.00 bill, and they are only going to get reimbursed $11.00, they feel they can't afford the difference. And, some senior citizens wait until they are at the point of acute illness before they visit their physicians, maybe needing to go to the hospital. We believe that this situation must be reversed. Thank you.

SENATOR HAMILTON: Thank you, Mr. Gottberg. Is Mr. Kelly with you?

MR. GOTTBERG: Yes.

SENATOR HAMILTON: Is he going to make a statement, or is he just here to assist you with the answer to any questions?

MR. GOTTBERG: He is going to make a statement.

J O H N K E L L Y: Our claim is based on the fact--

SENATOR HAMILTON: Are you Mr. John Kelly?

MR. KELLY: Yes, I am Mr. John Kelly -- John E. Kelly, Teaneck, New Jersey.

SENATOR HAMILTON: Proceed, Mr. Kelly.

MR. KELLY: Our claim is based on the fact that there is misadvised use of regulations of Title 42 of the U.S. Code, Subdivision 1395, known as the Public Health and Welfare Title, as now written into the title. The above applies also to the regulations as set forth in the Code of Federal Regulations 42 Public Health regulating the title, revised in 1978.

The above mentioned misadvised use results in defeating the intent of the Congress when the Title was enacted. The misadvised use of the regulations is by the carrier, Prudential Insurance Company of America, with the approval of the U. S. Department of Health and Human Services, under the Health Financing Administration. This approval was obtained at the Regional Office Two of Medicare, located at 26 Federal Plaza, New York City, New York, resulting in discriminatory treatment of the subscribers to the Medicare Part B Program, and is in violation of the intent of Congress when the Title was written. It further results in widespread dissatisfaction with the process of their claims by a great majority of the aged subscribers to the Medicare Part B Program in the State of New Jersey.

Since September, 1977, to date, we have examined the said Title and Regulations and we believe that over this long period of time we have acquired sufficient material evidence to support the validity of our claim in the name of our organization, The New Jerey Federation of Senior Citizens.

We also, in 1979, had written a position paper on this subject. We have presented the above mentioned material evidence, with our position paper, to the following organizations and persons over a long period of time. They all have been furnished copies of the material and the position paper. They all, with one exception, expressed sympathy with the validity of our claim. But, over this long period of time all persons and organizations have either been

unable or unwilling to give relief to the aged subscribers in the State of New Jersey under the Medicare Part B. The results to date have been nil. There are over 800,000 subscribers to the program, all over 65 years of age.

We have consulted with the following people over this period of time: Vice President James W. Long -- Vice President of Prudential Insurance Company; General Manager Wilfred Myer; Assistant General Manager John Gamble; Public Relations man, George Bauer; and Field Representative Freitag. These are all top administrators of the Medicare Program of the Prudential Insurance Company in New Jersey. We have, many hours and over long periods of time, consulted with them on this matter, with no relief as to the substance of our claim.

The Prudential still insists that their position is correct, quoting the offical approval of the Medicare Region Two and their oversite officials, located at 26 Federal Plaza, New York. In this approval, we respectfully disagree.

Contact with members of Congress -- We consulted with them personally and with members of their staff over long periods of time on this subject. We furnished them with all the above mentioned materials and position paper, with an answer from Prodential on the position paper. We consulted with Representatives Maguire, 7th District; Roe Paterson; Florio, 1st District; and Hollenbeck, 9th District. Hollenbeck is a minority member of the Subdivision on Aging, chaired by Claude Pepper, Florida. We contacted Hollenbeck in the Fall of 1979, had one public session with him, and one subcommittee hearing on the matter. We gave testimony at both hearings.

We contacted and consulted with the following H.E.W. officials: Medicare Chief John Brower, Region II; Liaison Officer of Region II, Mr. Hatam; H.E.W. offices in Baltimore and Washington; Offices of Medicare; Lisison Officer on the Hill, Mr. Al Miller; Secretary to H.E.W., Mr. Larry Gage; Office of Congressional Affairs, Mrs. Caroline Falley; Public Advocate, Mr. Van Ness, and his assistant, Mr. Tetelman. Both Mr. Van Ness and Mr. Tetelman acquired materials and a position paper.

Over a period of one and one-half years, we gave testimony before and offered our material and position paper to the Bergen-Passaic Health Systems Agency Ad Hoc Committee and other committees of the H.S.A. at many meetings.

State Health Coordinating Council, known as SHCC -- contact and May 22, 1980 letter from Joseph C. Kale. We have given testimony to the special committee on this matter on June 16, 1980, with material evidence and our position paper. We have not to this date heard from them as to any future meetings or dates or locations, but I expect will hear from them eventually.

Finally, on July 11, 1980, I stated before our Executive Board that the time has passed for any further rhetoric. There is no further room to squirm. Therefore, I recommended and set forth in a resolution to the floor, that the Executive Board, in the name of the New Jersey Federation of Senior Citizens, file an official complaint with the Medicare Region II and request a full hearing on the complaint so that we be given the opportunity to give evidence to support our claim; that all persons in that regulatory body, Region II, who have had supervisory power over the carrier, Prudential, be there; also, any persons who exercise approval of the carriers' proposals or actions related to the above complaint in question, Part B of Medicare, be there at the hearings. The resolution was seconded and discussion was held. A vote was taken and passed, and the President of our organization has been directed to make that complaint.

Rehetorical burdens on our complaints by seminars, subcommittee hearings-- The subversion by other very meritorious issues-- The repetition of those issues at the same time becomes a rhetorical burden to this issue, which must be addressed alone. The issue is that the State of New Jersey subscribers to the Program, Part B, as noted above, have been, are, and will continue to have discriminatory treatment of their claims until corrective changes are made in accordance with the present regulations.

Now, as my colleague stated, there was a change from eight localities to three localities. The original complaint was not the change, it was that one was in Atlantic City and one was in Camden. The first recommendation of H.E.W. was to broaden those two. Then, Prudential made a proposal to split our State into three localities, which throws the whole thing into a jumble. Now, in California, they have twenty-eight localities. In Texas, they have six. In various other states, they have the same process of handling their localities. What is the reason?

In Georgia, where the same carrier is also Prudential--

SENATOR HAMILTON: Mr. Kelly, before you get too deeply into those districts - they are districts and not regions - let me say this: I appreciate the fervor with which you bring your complaint here, both you and Mr. Gottberg. I appreciate the understanding that you have given to me, and the staff - It is being made a part of the record here today - with respect to the problems of senior citizens, who are certainly among the people who feel the ravages of health inflation as much as anyone does, because most of you are living on fixed incomes. I understand that.

The things you are talking about now seem to cry out for redress.

MR. KELLY: I beg your pardon?

SENATOR HAMILTON: They seem, very much, to cry out for redress. But, you are not going to like what I am going to say to you right now. That redress can't possibly come from me. It can't possibly come from my other 39 colleagues who sit in this Chamber, nor from my colleges who sit down the hall -- the 80 of them over there. There are some things we may be able to do. The process that we are working on today is the beginning of trying to have some state presence until there is some realistic federal action on line that means something, not only to senior citizens but to everybody else who is caught up in the same kind of a bind, where double digit inflation and health costs exceed the rate of inflation. What you are talking about is a matter that you are appropriately taking to federal authorities. What you are talking about is a matter that you have in the past appropriately taken to the members of the Congress, both the Senate and the House of the United States.

It is not within my power to change the regulation or the way it is implemented, either by the Prudential or by the Medicare Region. I can't change that. I couldn't change it even if I was 100% sure that you were right and if I was the only man that could act here.

I am glad you came. I don't suggest that I have gotten nothing from your remarks, because I have gotten a great deal from the remarks that you have made. But, I can't do anything about that situation. I suspect, because of the presentation that you have already given to me, that you are making your position on that known pretty well to a lot of people, and I wish you good luck.

MR. KELLY: Yes.

SENATOR HAMILTON: We want - not today, because there has been a lot of work done by this young lady before today - from today on, as well as what has already been done, to try to respond within the capabilities of State government, and to try and solve these problems. We are not going to be one hundred percent effective. I started out - if you were here, I don't know if you were - by saying that I don't know if it is within the realm or the ability of this State government, or any state government, or the Federal government, to solve those problems. I think some of those problems are solved by individuals, including individuals like yourself who stand up and be heard when you think you have been wronged. They are solved by the private sector, with or without a profit motive, depending upon the kind of organization or group that you are taking about. And, they are solved, in part, and hopefully cooperatively, by people in government, in both the Executive and the Legislative branch. So, we are going to be doing our part in that.

I hope that we can help maybe not your specific problem, because we can't help with that, but with the overall problem that you and members of the New Jersey Federation - and people in general, whether they are associated with the Federation or not - have in terms of - and I don't know whether it was you or Mr. Gottberg who said this - depriving yourselves of care that is needed because you don't get back what it costs you. That is something that we are deeply concerned about. That is something that, if we find the right answers, we can do something about. We truly can't do anything about the quarrels you have with Medicare and the quarrel you have with Prudential.

But, I appreciate the figures you have given to us. If you have any other specific data, either now or later, I wish you would communicate with Mrs. Seel about the average rate of reimbursement for the kinds of care that you and members of your organization have. I think that would be most helpful to us.

MR. KELLY: May I add something, sir?

SENATOR HAMILTON: Yes.

MR. KELLY: We refrain from coming before state organizations, except for the Advocate, because up until now there was no committee that we could come to with this complaint. These were changes made in the locality with the approval of the State. We have correspondence to show this. We were invited here today because this is a new committee. We would like, with your permission, to meet with your staff and lay out this problem. It is a New Jersey problem.

SENATOR HAMILTON: It is a New Jersey problem because it affects the geography of New Jersey.

MR. KELLY: In its difference from the other states.

SENATOR HAMILTON: I would like you to get together all of the documentation you have. I do not think the change was with specific legislative sanction, but to the extent that it was signed off by either the Department of Health or by the Department of Insurance, yes, we would like to have those materials. I am sure Mrs. Seel will give you the mailing address. If you don't want to come back down on any given day, you can certainly mail it to us. We would like to have that information.

MR. KELLY: We will be very willing to meet with anyone who will listen to our complaints. I have here a statement by Congressman Maguire. He made it after this special hearing, and he agrees with us on this. It is not the fault of the legislature. We are not talking about new legislation; we are talking about the legislation, how it is handled in this State.

SENATOR HAMILTON: And how it is interpreted, and whether or not there has been any oversight. If you have a copy of the Congressman's remarks, we would like to have that too. But, in particular, we would like to have the implementation at the state level of the things that you have complained about. We would like you to submit them to us.

MR. KELLY: Thank you.

MR. GOTTBERG: Thank you. The reason, of course, that we came to New Jersey, and we go to the legislators in New Jersey and know practically all of them, if not all, is because we can get more done within the State. By going to the State Legislature, either the State Assembly or the State Senate, we can get our story across. For us to try and go to Washington is practically an impossibility. We couldn't afford it in the first place. Then, New Jersey is only one out of fifty states, so that the problem, if it is nationwide, becomes practically impossible for a group in New Jersey to handle. So, we have been very successful in at least getting our story across to the legislators and having them on our side.

The problem is a New Jersey problem. Now, whether New Jersey can handle it or not, we are not sure. But, it is a problem in New Jersey, especially the cutting down of localities from 8 to 3. There is a possibility that you and your collegaues in the Senate could do something about that by pushing legislation, even if you are not personally involved with it.

SENATOR HAMILTON: Let me give you one or two comments, and I know you are going to leave then. First of all, I am glad we have that reputation with the New Jersey Federation of Senior Citizens. You are right, you can get to us. You are right, you have generally been effective in getting things done with this Legislature. I am proud to be a part of the Legislature that made that a possibility. It is because of your tenaciousness and the way that you come here that that is true to a large measure. You are right, the problem you describe is a New Jersey problem, but it is a New Jersey problem under federal law. There is that much input by the State, that much sign-off by the State -- it is a New Jersey problem, but it is under federal law. One thing I never like to do is to hold out false hope to anyone, including someone who is nice enough to come here and say that this Legislature is responsive.

We will look at those papers you have, but I don't think there is very much we can do about this particular problem. In terms of health costs generally, I hope there is a whole lot we can do before we are finished. And, I am sure we can count on you for help.

MR. KELLY: May I address myself to a remark you made earlier? It has nothing to do with this. You stated how the cost of health care has graduated over a period of time. Well, there is one subject that has not been approached here today, not that I heard at least. The point is, there is a contest in America that is across the board, between the providers and the insurance companies. The insurance companies keep competing with each other, offering more and more benefits, and the providers oblige them. Now, as old as I am, I can give you some examples of that. I have a son who is 33 years old. He was in the hospital when he was 3. It was $8.00 a day for a private room in Babies' Hospital in New York City. I recently was in that hospital myself, a year ago, and it was $255.00 a day, and that didn't include many of the supplemental coverages they gave you for the $8.00. Now, that contest has been going on between the insurance companies and the providers for the last 15 or 20 years, and I think you might

be familiar with it because you have seen this too. Prudential competes with another insurance company and raises the deal, then another one competes with them and they raise the deal. The actuaries go up in their ivory towers and they have a session, but the don't ask the people. The point is, that has to be adjusted. This is something that you should hear. When they enacted the law, sir, they excluded the fact that, "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or in the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person. Now that is the crux of the thing. We hear all this talk about government regulation, but the fact remains that there is where the aristocracy started.

SENATOR HAMILTON: And we will hear more about that before we are finished. Thank you, Mr. Kelly. Thank you, Mr. Gottberg.

I am going to take one more witness, although it is a little bit later than I thought, because there is a time problem. Dr. Bruce Vladeck is the Assistant Commissioner of the State Department of Health. We will attempt to break for about 45 minutes after Dr. Vladeck testifies, and then we will return so we can hear as many of you as possible -- hopefully, that will be all of you today.

Bruce, you need not feel that you have to read all of this statement. If you want to highlight it, it will be in the record. (see page lx)

B R U C E V L A D E C K: Oh no, after making an appropriate thank you for the opportunity to be here, I was going to tell you that you have eight copies and you are free to do with them as you will. In the interest of everyone's appetite, I will try to keep this very brief.

The first thing I do want to do, however, it to convey Dr. Finley's personal regret at not being able to attend. In addition to our institutional, departmental interests in these issues, she has a very deep personal interest in many of these problems and was eager to come, but the Health Care Administration Broad meets the first Thursday of every month and by statute she has to be there.

It is not well known, but among her many other accomplishments, although she mentions it frequently at the Rate Setting Commissions, Dr. Finley is a former Vice President of a Blue Cross plan, and her interest predates that period, and certainly has extended since.

Let me say,very quickly, just the few things that I wanted to say. I was able to pull together some data, but Mr. Melman has presented much the same information, and probably better than I could.

We are, as you know, charged under S-446, which the lawyers are now telling us to call Chapter 83 of the laws of '78, with the responsibility for cost containment, and as we have gone into the implementation phase, we have reached a whole new world of payers. We have been regulating hospital rates since 1975, but we were dealing with Medicaid and Blue Cross. We now have, literally, hundreds of new constituents out there, and it is a new experience for us. We have learned quite a lot. We haven't done nearly as good a job as we should have of communicating with them. The list of people who write commercial health insurance in this State runs to a number of pages, and we didn't even have the kinds of mailing lists in place that we needed. We are learning.

We have learned some things which have provided some lessons that we would like to see lead to some suggestions. But, the other point is that we are also responsible as the State Health Planning Agency for preparation and implementation of a State health plan. Through the arduous work of the Statewide Health Coordinating Council, such a plan was developed. It was transmitted formally by the council to the Governor and it was accepted by him as the state plan. One of the major priorities in the plan is a substantial expansion in the insurance coverage for outpatient and preventative services, largely keeping with the entire emphasis on the plan, which diagnosis the cost problem in health care in this society as being largely one of mis-emphasis. It does this in the sense that, to a considerable extent because of insurance, we have built a very elaborate, very enormous, very expensive sector of care, of acute illness care. We are seriously undersupplied with the kinds of cost effective, preventive public health care that can prevent acute incidents, or make them less expensive when they do occur. One of the only ways you can reorient the system in order to expand the preventive and outpatient sector is by expanding the insurance coverage.

As was presented to you today, something like 95% of the population of this State has insurance against a routine, acute hospitalization. I would venture to say that more than half of the population of this state has no insurance coverage for immunizations or well baby care of young infants, which is the single most cost effective form of medical care ever developed. Most insurance contracts routinely exclude preventive visits. We have come to learn in the last number of years that the annual physical is probably not a necessary preventive activity. On the other hand, there are some preventive examinations for people with histories of certain diseases in their families, or themselves - pap smears, and other kinds of preventive activities - which are not routinely excluded in most insurance contracts, and which, in a number of instances, can prevent or delay the onset of very much more expensive acute episodes for which we do provide insurance.

In keeping with the priority in the State Health Plan, therefore, we have held conversations with the Department of Insurance, and we are currently at work drafting a talking draft of what we have called a Health Insurance Reform Proposal. That is probably a misnomer, because that is too broad a name for our somewhat narrow objectives. We did this with the encouragement of the Governor's Counsel's office. In this, we would try to establish a certain uniform minimum of preventive and outpatient services with demonstrable effectiveness, that would have to be insured by anyone who covers basic, inpatient, acute hospital services. Once we have a draft, we have already committed ourselves to the insurance industry, and they have shown considerable interest in substantial public discussion and information exchange before any formal proposal comes about. We are delighted by the conjunction of this activity growing out of the State Health Plan and the actions of this Committee, because we do think there is obviously a convergence of work and interest. I would hope that within the next six to eight weeks we will be able to present to you - again, not as a formal legislative submission, but rather as a talking draft - some specific recommendations along these lines.

Let me say two other things very quickly. The first is that there is a national phenomenon going on that is true in New Jersey as well as anywhere else, and that is that one of the things inflation is doing is progressively disenfranchising people from Medicare eligibility. In New Jersey we have done a substantially better job than most other states in keeping the income eligibility levels

for public assistance somewhat in keeping with the general rise in the cost of living. But, if you talk about real, disposable, out-of-pocket income when you have 12% and 13% inflation, the number of people who are truly medically indigent, who do not qualify even under our continually liberalized income eligibility standards for Medicaid grows constantly. This has been one of the reasons for the acute crisis of the urban hospitals. While Medicaid containues to pay its share, a smaller and smaller proportion of their poor patients are Medicaid recipients.

I think to some extent that problem argues for a medically needy program, although the experience of New York has been that even in inflationary times even a very generous medically needy Medicaid program leaves lots of people without coverage. I think it does argue for the kinds of provisions for financial stability of hospitals that are contained in 446, and we are seeing some very encouraging improvement in the financial status of some of the inner city hospitals as a result. But, that doesn't get to the services that we are most eager to encourage, in terms of well-baby care, in terms of maternal nutrition, in terms of preventing the preventable diseases -- and there is a distressing amount of preventable disease in the inner cities of the State of New Jersey and in the rural areas of the State of New Jersey.

I don't know whether within its limited fiscal powers the State can solve these problems. I don't know what the best approach to them is. We are deeply concerned about them. We are eager to provide whatever assistance we can to this Committee as it address the problems, and to work with you to try and see what we can do.

On that, everybody's hungry, so I will stop talking. I will be happy to answer any questions you might have.

SENATOR HAMILTON: Commissioner, I appreciate everything you had to say. I am delighted we will get to see something, in terms of rough draft legislation, and in terms of the front end, or preventive aspect of this. Are you here to make any comment at all in the general terms of catastrophic illness problem mentioned by Mr. Cottingham and alluded to by others?

COMMISSIONER VLADECK: Our consistent position in the Department in terms of the convential catastrophic proposal of a very large deductible up front in insurance coverage. Insurance against catastrophic illness has always been something that we thought was aptly named, and that we have opposed, in large part, because except for people who need certain kinds of services that we believe are truly social responsibilities , we are not convinced they can rationally be provided for by insurance, such as those who suffer catastrophic accidents. The problem of health care cost is twofold. On the one hand, it is access - people who have no coverage. On the other hand, the catastrophic expense is experienced by some people who do have coverage, but that doesn't cover certain kinds of catastrophic expenses. Most of the things that move you towards catastrophic coverage tend to leave out 5%, 8%, or 10% of people who aren't covered at all.

Take the case of someone like Mr. Cunningham, for instance. A vocational rehabilitation department should provide a medically needy program, with a spend-down provision in it, and with room for some expansion. This is in the legislative hopper right now -- eligibility for Medicaid coverage for the disabled. That would minimize the problem, but if you talk about a general provision where everyone who gets insurance has an unlimited ceiling on Major Medical, what you are then doing is driving up the price of an insurance package for all the people who haven't any insurance at all and who aren't getting the necessary, cheap preventive

services. So, to the extent that we would be supportive of catastrophic insurance, we would say there would have to be a second step, or a simultaneous step, with some way of addressing the issue of coverage for the people who have none, or who have none for what may be the less catastrophic expenditures, but that is more discretionary. There are children in this State who aren't getting immunizations, who have visual defects, who can't study in school, who can't get a pair of glasses, and in the aggregate that is a more expensive program program and, in many ways, it is less politically appealing. But, the social mechanisms to help those people are much less well developed than the things that can be patched together, in most instances, for catastrophic illnesses. We think we can patch on catastrophic; the place to move is on the people who have no coverage.

SENATOR HAMILTON: I haven't heard anyone - in particular, I remember Mr. Melman's testimony, and he was not insensitive to it - testify who were insensitive to the problems of people with no coverage. So, I don't think it is an either/or proposition, and I don't think we are singling out one or the other. It would seem to me that except in the case of - to talk about the deceased - Mr. Rockefeller, because that is the name we always threw about, there is no one who is financially able, out of his own resources, to meet the cost of care for a major form of cancer. There is no one who has a quadiplegic type of injury who can.

I can think of one from my own knowledge concerning a lawyer who was quite successful. His son suffered a pariplegic type injury in horseplay with his brother in the back yard -- absolutely no insurance coverage, or if there is, perhaps it was very limited coverage under a homeowner's policy; I am not familiar with the details. He will practice law for the rest of his life, but he is never going to have the resources to pay what has already been paid for his son's care in those first few months. So, except for the most wealthy - the one-quarter of one percent - in our society, there is no who who is able to meet the kinds of costs that a significant number of people in society have had to meet today. And, when I say that, I have no intention of excluding anyone from consideration - and I hope the range of areas that we talked about this morning made that clear. We are certainly concerned about the poor. We are concerned about them being on their own, and we are concerned about them because of the continued viability of our hospitals, particularly in the urban areas.

So, I don't think this is an either/or; I think it is a conjunctive kind of approach.

COMMISSIONER VLADECK: I may not be expressing myself as clearly as I want to. One of the issues related to that, for example, is the fact that for people who have very large medical bills in a year, they overwhelmingly tend to be in hospitals. Now, when you enact a statute that says that hospitals must follow good billing procedures, but if they have bad debts, subject to good billing procedures - as we have had - they shall be reimbursed for those costs. In fact, I think that under Senate 446, a very large number of those bills will now be written off by hospitals, appropriately. They are required to do so under our regulations. Those burdens will be relieved in that way.

But, frankly, I have a vision of our recreating a problem. I don't mean to say that we shouldn't do anything, but we are recreating what we have done with nursing homes, where we have said that this is essentially a medical problem to be covered by an insurance mechanism. I am just not convinced that the conventional insurance market, per se, is the appropriate way in which to

approach that. If we want to establish a statewide no fault poor that is covered out of general revenue taxes or premium taxes on all health insurance, that might seem to me to be a very sensible thing. If we want to directly state subsidize for certain kinds of catastrophic services; if we want to follow the example of Medicare with renal disease, which picks a certain illness that is catastrophic in its expense, and says, "Everyone who experiences this will, by definition, become eligible under a public insurance program" -- I think all of those are approaches to what I acknowledge is a very serious problem. But, when one talks conventionally about catastrophic insurance for what one tends to see when it gets to federal legislation, at least, or bills in other states, he is talking about removal of the dollar limitation on a Major Medical policy, or some kind of reinsurance through the conventional insurance market. I am not sure that would be the best way to handle these problems.

SENATOR HAMILTON: Well, it may be better than no way of handling them, but let's leave that because I don't want to make conclusions today. But, one thing that you said struck me, and I want to put it into context with what I think Mr. Melman said. You suggested that it is essential that we have, either first or contemporaneously with any catastrophic illness, an expansion of Medicaid so that we have a medically needy program. I understood Mr. Melman to indicate that the problem with New York hospitals was the absence of a cost containment mechanism such as 446, yet New York has medical needy. Maybe this is an unfair thing to ask you because I am taking somebody else's thesis as well as your own and putting them together. How do you harmonize those two viewpoints if I want to accept both of them?

COMMISSIONER VLADECK: Well, the first thing to be said is that New York probably operates-- We keep reminding the New Jersey hospitals that if they think we are mean to them, they ought to go over to New York, which probably operates the most stringent form of hospital.

SENATOR HAMILTON: From the things I have heard, that is not much solace to them.

COMMISSIONER VLADECK: Seriously, the New York hospitals are not receiving any reimbursement for their bad debts. They are not receiving any reimbursement for their medically indigent who aren't covered by Medicaid, and they are going broke. My point was that medical indigency under the federal limitations-- If we enacted the most comprehensive program we could as an expansion of our Medicaid Program within existing federal regulations, it would still leave a lot of people in this state not eligible for Medicaid coverage, and a lot of the clients of our inner city hospitals not eligible. That has been the experience in New York, which has a generous one. In New York they say a lot of the problem is associated with illegal aliens, which may also be a problem in some of the cities of this State. But, if you go as generous as you can under federal Medicaid guidelines, you still leave a substantial number of people who have no kind of insurance and who can't afford to pay for services.

SENATOR HAMILTON: The difference between you and Mr. Melman, if there is one, is one of degree only. With the medically needy you would say that we are still going to have a lot of people who end up as bad debts to the hospitals and they are still going to have a problem, and that is not totally inconsistent with what he said. He said we would improve it, certainly, if we moved it in the other direction.

COMMISSIONER VLADECK: Right.

SENATOR HAMILTON: Thank you very much. I am sure we can call on you for your resources in the future, and I assure you we will do so.

COMMISSIONER VLADECK: I look forward to it.

SENATOR HAMILTON: Thank you very much. We are going to break now at five minutes of two. If there is anyone else who wishes to testify this afternoon, other than those who are on the list, please let us know when we break. We will be back at 2:45.

(lunch break)

SENATOR HAMILTON: Good afternoon. I apologize to you for the delay in getting back. I would be tempted to blame it on a Trenton restaurant, except that those of you who didn't get any lunch at all wouldn't be impressed. I think that we're on the down side of the curve. There's only about four people left who do want to be heard and I think, because I know most of them, that they all will have a contribution to make. So, without any further remarks from me, I would like to call Mr. Thomas Russo, Director of Division of Medical Assistance and Health Services for the New Jersey Department of Human Services.

T H O M A S R U S S O: Senator, I want to express my appreciation for the opportunity to address you at this time. I know you've had a long day, so I thought I would flank myself with two persons who are a little more pleasant to look at than myself for your edification.

SENATOR HAMILTON: I agree.

MR. RUSSO: This is Ann Kohler on my left and Margaret Kerchner on my right.

SENATOR HAMILTON: I think I've had the pleasure of meeting both in the past.

MR. RUSSO: As you know, the medicaid program in New Jersey provides very broad coverage for those persons who are eligible for the program. There are approximately 630,000 citizens in this state who are beneficiaries of medicaid program coverage. That group, I think, does not really have to worry about medical or health care because, essentially, all of their care is taken care of by the government sponsored program.

There is another group is New Jersey that are eligible for drug benefits under the Pharmaceutical Assistance to the Aged Program and that's another group of about 280,000 persons in addition to the 630,000 under medicaid, who have part of their health care taken care of in refererence to prescription drugs.

Someone mentioned earlier today that there is a medicare gap in this area because medicare does not cover prescription drugs for persons who live in the community. We are talking, here, about, if you add it up, about 900,000 persons in the State of New Jersey, part of which group has full health and medical care coverage and part of another group has drug coverage under State Government sponsored programs, aside from any private insurance or medicare benefits.

However, there are some very, very serious gaps in the coverage available to individuals in this state. I would just like to give you four examples, if I may, of potential gaps that seriously affect individuals.

The first example refers to a child with a severe birth defect requiring a respirator and skilled nursing care. This child may be eligible for supplemental security income eligibility in an institution and S.S.I. considers him or her as a single individual. However, when the child returns home, the income and resources of the child's parents are considered to be available to the child. He, then, is ineligible for S.S.I. payments and/or medicaid. Medicare, obviously, is not available. Private insurance does not always cover the catastrophic expenses required: private duty nursing; respirators; etc. The family may have income in excess of any medical needy coverage, assuming that we had a Medical Needy Program and therefore, they have some severe problems in meeting the health care needs of that particular child.

The second example--and I'm giving these examples to demonstrate that there are various categories of people in New Jersey that can fall through the cracks

in receiving necessary, needed health care, even though we have such programs as medicare, medicaid, PAA, various private insurance programs, group insurance and so forth. The second example is an adult with a severe illness that will necessitate long-term home health care. Here, a mother of two children, small children, may have major surgery that will incapacitate her for several months. She may require home health services and her personal care services as well as homemaker services. The income of the father or husband may be far in excess of any categorical or medically needy standard, again assuming that we had a medically needy program. Medicare would not be available to that individual.

The third example would be an adult who is not age 65, blind or who will not be disabled for a 12 month period. That individual is not eligible for either categorical or medically needy coverage. The individual is not eligible for medicare or medicaid. He may qualify for general assistance coverage if the income of the individual is less than $178 per month. If the individual with that amount of income per month qualifies for general assistance, he may have excessive medical bills, but he would not be covered for in-patient hospital care or physician's services related to the in-patient hospital care.

The last example that I will give, although there are many others that we could illustrate, an individual who is in need of long-term care, who is unable to be placed in a long-term care facility or nursing home because of a lack of available beds in the state.

If we had a medically needy program with a standard, for example--

SENATOR HAMILTON: Tom, before you go to that, only because I missed it, what was the difference between the second and third categories that you mentioned, the adult with severe illness requiring long-term home health care services and the adult less than 65, blind, disabled and so forth? I didn't see how you distinguished that from category 2 or situation 2.

MS. MARGARET KERCHNER: In the second situation, the person would obviously be considered against a family, an AFDC standard. In the third situation, the person is a general assistance recipient. That is the only program they qualify for because they don't fit into any of the other categorical program types.

SENATOR HAMILTON: Thank you.

MR. RUSSO: The fourth example, as I started to say, would be a single individual with an income of $364. The SSI medicaid standard would be $261. Now, this individual would not be eligible for general assistance. The medicare limits coverage for home health visits to 100 visits under part A and also 100 visits under part B, if the premium under part B is paid. If this individual does not have private insurance coverage for home health services, her home health benefits would last only fifty days.

Now, these are, as I said, Senator, just a few examples to illustrate that there are serious gaps in medical coverage that do exist.

Now, how can we address some of those issues? Obviously, we could consider some sort of catastrophic health care program in the state that would tend to fill many of the gaps that we speak of. In addition, as has been previously stated by other speakers, we could consider a medically needy program. Obviously, I am speaking of need here and not the ability of the state, at this time, to finance these kinds of programs.

One of the things that I think we should seriously address, when we speak about medical care and health care, is the physician's role in this whole program.

The physician, and we seem to tend to forget the physician and when I say physician, I see it, more or less, in the generic term meaning individual practitioners than the chiropractors and so forth, but the physician is responsible, really, for ordering about 80% of all the health care benefits that individuals in this state and in the country obtain. If you stop to think of it, he or she is the individual who admits a patient to the hospital, determines how long a patient will stay in the hospital, admits a patient to a nursing home, does about the same thing, writes the presecription drug, orders the X-rays, orders the physical therapy and we can go on. Without the physician, we would have no health care program to speak of. We would have hospitals and nursing homes, but the care and the treatment that is provided in those facilities are ordered by the physician. What I am simply saying is that we can talk about health insurance programs, whether they be privately sponsored or government sponsored or combinations thereof, and we can talk about all types of legislation to provide that kind of coverage, but unless the physician and the other practitioners are there and available to provide that service, we really don't have much of a health program. It has been mentioned earlier that under the medicare program physician assignments are dropping drastically because of the low rate of reimbursement under medicare. That same phenomena exists, for example, in medicaid where the reimbursement to physicians is probably at 50% or less today of usual,customary fees. That same situation is existing throughout the country and I know of only one state, at this time, that is reimbursing physicians at their usual and customary fee or near about that in the medicaid program and that is the State of Maryland.

What I think we should do in this entire context is, somehow, to get the physician more involved. I am more and more concerned with the physician's involvement with indigent type patients and the medicaid type of patient and provide some type of incentive for that physician to provide the care. One thought that might be given consideration, and I know this may not be too enthusiastically received because physicians, as a group, on the average, are the highest salaried people or income people in this country, but we might want to consider, if we don't have the resources, increasing reimbursements to physicians under government sponsored programs to possibly give that physician some sort of State Income Tax credit, for example, for providing services to an indigent patient or to medicaid patients. They might be difficult to administer, but it is a thought you might want to give consideration to.

The other thing, one of the other speakers mentioned the emphasis on providing care in hospitals in the out-patient departments, as opposed to in-patient hospital care. I would agree that that is a laudable objective and providing care in an out-patient setting, obviously, is far less costly than doing the same thing on an in-patient basis. However, out-patient care, again, is extremely expensive. If we're talking about primary medical care and I'm not talking about emergency care because emergency care belongs in the emergency room, in the out-patient department of the hospital. I'm talking about primary medical care in which people receive that care in a hospital setting and do not receive it in the physician's private office. It is probably the most expensive type of primary care we can give. It is probably the least effective. It has no continuity to it. You see a different physician all the time. You don't have the patient's full medical or family records and we should try to develop a system to provide incentives to physicians to see those patients in their private office and not to see them in a hospital's out-patient department. We could save millions of dollars each year by doing that. We could provide the patient care, more quality care in the proper setting.

These are just some thoughts that I thought I would share with you and your committee. I think that what we are talking about is something that is very difficult to do. It is trying to change a pattern that exists and has existed over the years and that pattern really exists. I'm addressing myself, again, to out-patient hospital care because I know from our experiences in the medicaid program that we are spending millions of dollars in paying for that care that could more properly be given by the private physician in his office setting and in considering this whole area of health care, I would hope that you and your committee would consider some type of incentive to move that system in a different direction. We might even be able to save enough money to put in some sort of catastrophic type of program to care for some of the people who fall between our health care cracks today.

SENATOR HAMILTON: Thank you very much, Tom. Let me ask a couple questions, if I might. You mentioned that Maryland, that you are aware of, presently reimburses under medicaid at something approaching the customary charges. How long has that been the case?

MR. RUSSO: I don't know how long that has existed. I do know that for a regular office visit, they are reimbursing about $15.00. I don't know how long they've been doing that though. I think their rationale for doing that is that they feel that it is cost effective to do so.

SENATOR HAMILTON: We were told this morning by the senior citizen representative that we were reimbursing in New Jersey at the $15.00, but that the charge is about $30.00. It is unfair to draw any conclusions based on a single kind of service, but do you know whether their reimbursement at customary charges was implemented contemporaneously with rate setting mechanism or are they two separate phenomena?

MR. RUSSO: I would guess--and I really don't know--but I would guess they were probably done separately. But, I really can't say for sure.

SENATOR HAMILTON: Now, you have talked and you have given us four, perhaps five, rather cogent examples of gaps in the medicaid coverage and you have refered to a medically needy program. Now, you know and I know that bills to accomplish that have been in the Legislature at least for the last two or three sessions. A-76 is the one number that jumps to mind. Assemblyman Deverin had that and he may have had the prior bill. I'm not sure. Your Department has had occasion to look at that and,I suspect, lobby for it at one time or another. Have you crossed it out?

MR. RUSSO: We did cross it out. Of course, when we were speaking about a medically needy program, there are many options in which you can develop that program. You can provide a full range of services that are comparable to the regular medicaid program services or you can provide a very restricted or limited amount of services and then you have flexibility, also, within that of establishing the eligibility standard; for example, either 101 or 110% of AFDC or you can go all the way up to, for example, 133%. So, you can talk about a medically needy program with a wide range of services and coverage benefits and with a wide range of costs. My guess would be--and we did do a preliminary study on this. It is not really in a final, publishable form, but the costs could range anywhere from the most restrictive type of program, running around, possibly, $15 million up to, possibly, $50 million or $60 million, depending on how you define your program.

SENATOR HAMILTON: Are those numbers available, even though they are not "publishable"?

MR. RUSSO: We would be happy to make them available to you for your information.

SENATOR HAMILTON: We would appreciate having that from you. Assume the number 50 or the number 15, what are you going to get back? What is New Jersey going to get back besides the health of the people, which is a considerable consideration? But, what are we going to get back by way of federal dollars by way of reimbursement, if anything?

MR. RUSSO: Well, there are several benefits that would accrue. One of the benefits, of course, would be, as you mentioned, that we would draw in federal money to provide health care in a segment that is not being covered at the present time. The other is that there are some tradeoffs that would occur. For example, some persons who might be eligible now under PAA might become eligible in this program and there are some other programs in which there are some tradeoffs. So, we could be saving some money in other areas, but they would also become eligible for medically needy as well.

SENATOR HAMILTON: Well, with respect to the federal reimbursement, what kind of numbers or what kind of percentage or what kind of formula would you be talking about there?

MR. RUSSO: We would be talking about a 50% matching formula. The 50%, it would be 50% federal and 50% state shared. We also do have the option in the state of using a different sharing type formula by including municipalities in the sharing formula, which we really do not do on any major basis in the medicaid program at the present time.

SENATOR HAMILTON: Would you want to amplify on that, please?

MR. RUSSO: New Jersey's medicaid program, essentially, is a 50-50 state-federal share program. You could have a third party in that program, that is, the counties could share in that program so that you might not have a 50-50, but you might have a 25-25-50 program. In essence, you be asking counties to pick up some the state share cost, but you would still be drawing the 50% from the Federal Government.

SENATOR HAMILTON: That would require legislation to assess that against the counties? There is no mechanism presently in place?

MR. RUSSO: That's correct.

SENATOR HAMILTON: And, even with a medically needy program, from what I have heard so far today, we would still have a problem with respect to those municipalities or those counties where you have large urban centers because by any definition or standard, you are going to have a lot of people who are not going to be able to pay. Even with the medically needy program, they are not going to have coverage and we haven't done anything to directly to assure that those hospitals are being physically solvent.

MR. RUSSO: That's correct.

SENATOR HAMILTON: So, what you are saying, in terms of the federal reimbursement, if you design a $15 million program, which is modest, it would cost the state $7.5 million. If you designed a $50 million program, it would cost the state $25 million.

MR. RUSSO: If that was the kind of sharing formula that was determined, yes. We would also pick up, in the tradeoff, some of the general assistance clients who would become eligible under the medically needy program and, as you know, general assistance, I believe, it is a 75% state match program and a 25% local match. So, we would be trading off some general assistance people at 75% state cost at a lesser cost.

SENATOR HAMILTON: Well, is it a direct measurement? In other words, let's take the number of $40 million and I will come back to that in a minute because it has been bandied about in other discussions I've heard. If we had a 50% reimbursement, it would be 50% federal and we would assume 50% state. That's $20 million that it is going to cost the state. Let's assume that in your offsets, in PAA, general assistance or what have you, that the cost to the state is not $20 million, but it works out being $16 million. Does that mean we're going to get $32 million or are we still going to get $20 million from the federal?

MR. RUSSO: Well, we would get what the combination federal, state and local match would be. We would get the equivilent of that in the federal match.

SENATOR HAMILTON: In other words, it is on the dollars that are spent on the program, without regard to any change in the process?

MR. RUSSO: That's correct. There is only one caveat in the federal requirements and that is, taking the medicaid program as a whole. You cannot exceed 40% in the total medicaid program as a combined federal-local match. In other words, the federal program is designed to put some sort of a limit on that kind of match.

SENATOR HAMILTON: You lost me with respect to that. I understood it was a 50% federal participation.

MR. RUSSO: Ann, are you familiar with that? Can you explain it better?

ANN KOHLER: The 40% share is the state and county. In other words, we can't ask the counties to pay for more than 40% of the state medicaid costs.

SENATOR HAMILTON: But, it doesn't reduce the federal match.

MS. KOHLER: It doesn't reduce the federal match, no. We get a dollar of federal money for every dollar of state money that we spend regardless of whether it is a savings from another program. As long as we spend a dollar, we'll get a dollar back.

SENATOR HAMILTON: What you're saying is, out of the ten dollars that we spend, if we got five federal, three state and we could get two county, if that's the way we structure it. So, it is not a limit on the federal reimbursement, it is a limit on what we could pass on to the county. Can you also pass on to the municipalities?

MR. RUSSO: The federal definition really doesn't define counties and municipalities. It makes reference to local share.

SENATOR HAMILTON: How many states have one form or another of a medically needy program?

MR. RUSSO: I believe, at the last count that we made, we had 23 states that had a medically needy program.

MEMBER OF AUDIENCE: There are 33 at last count.

MR. RUSSO: 33? Okay.

SENATOR HAMILTON: Can you furnish us--and I'll ask Ms. Chasnow the same thing when she comes up--if we can get a list, we would appreciate having that. In 1973, I believe--I know it was one of my first two years down here--there was a reduction or, at least, a perceived reduction in what we were doing either in this program or in some related program. Didn't we have a medically needy program in the late 60's, early 70's?

MR. RUSSO: No. We never had a medically needy program in New Jersey.

SENATOR HAMILTON: Do you remember that controversy about a curtailment in benefits for the poor or was it just in the rate of reimbursement?

MR. RUSSO: No. The medicaid program began in New Jersey on January 1, 1970. On or about 1975, somewhere in there, there was a shortfall in appropriations and the medicaid program cut back and reduced some of its services for a short period of time, for about a three month period, and then there was a supplemental appropriation and the program was restored in full. That may be what you are referring to.

SENATOR HAMILTON: Except for size, there has not been a change in the shape of medicaid, except for a temporary period of about three months in 1975.

MR. RUSSO: Basically, we added some services, when the program began in 1970. We had less services then we have now. For example, psychological services, chiropractic services were added. Podiatry was added. We added the ICF/MR program for the mentally retarded. They were all added as additional services.

SENATOR HAMILTON: I assume that what we have done, then--I assume that what the situation is, is that there is a federal requirement of things you must have and then there is a long list of optional things and depending upon how many of those you implement depends not the formula, but the amount of federal dollars that are geared by the things that you plug in that are on an optional basis.

MR. RUSSO: That's correct. There are mandatory services that, if the state opts to participate in the medicaid program, it must provide the mandatory services and then there is a whole list of optional services that the state may or may not participate in. New Jersey has a very liberal and comprehensive program and aside from the medically needy aspects of it, we provide almost all of the services that you can under medicaid.

SENATOR HAMILTON: In connection with the earlier versions of the medically needy legislation, was your office or your department ever requested to prepare a formal fiscal note?

MR. RUSSO: I recall that we did prepare a fiscal note when some of the first initial legislation came out. Yes, we did.

SENATOR HAMILTON: Could you draft a copy of that along with the other data that you are going to give us?

MR. RUSSO: Certainly. I would think it would have to be revised and updated.

SENATOR HAMILTON: Undoubtedly, it would have to be revised if it is even a year old and I suspect it is longer than that. What would the medically needy, in general terms, what would it add that we don't now have in the medicaid program?

MR. RUSSO: Well, what it would do, it would, again, depending upon the scope of the program, it could bring in, for example, approximately 90,000 additional persons who would obtain medicaid eligibility that are not eligible at the present time. That would mean that there are, say, 90,000 persons who now are over the medicaid income standard, are not eligible for health care services, but are in, still, an extremely marginal income situation where they can meet their daily living needs, but if they have any kind of health care problem with any degree of expenditure involved, it would mean that they could spin down to medicaid eligibility and receive benefits. At the present time, those 90,000 or so persons do not have the coverage under medicaid. Probably, unless they are in an employed situation, where they have some sort of employer insurance, probably, they are in the income bracket where they cannot afford to buy private health coverage.

SENATOR HAMILTON: So, what you are really saying is that there will be no change in the kind of services that are covered but only in the economic status and economic level of the people who will become eligible.

MR. RUSSO: Yes.

SENATOR HAMILTON: When we opted for the new ICF/MR program, that required the expenditure of how many additional millions of state dollars?

MR. RUSSO: That required, I believe, around forty million additional dollars, state dollars, in that program. I believe we're generating around $80 million or so a year in that program, with the federal matches.

SENATOR HAMILTON: Is that operating dollars or does that include the capital dollars?

MR. RUSSO: No, that does not include any capital money. That is strictly funds to upgrade what are federally required ICF/MR standards. It does not include basic funds for capital construction. The medicaid program does not pay for capital construction.

SENATOR HAMILTON: Well, there is some reimbursement, as I understand it, for the interest charges in connection with the capital construction when we are bonded.

MR. RUSSO: Yes. Some costs of capital construction could be included in medicaid developed reimbursement rates, but the program itself does not provide any lump sum payment for construction or renovation. The reimbursement is received through the formula used to develop rates.

SENATOR HAMILTON: I should remember what I'm going to ask you, but, in all honesty, I do not. When we moved to the ICF/MR program, was that purely a federal mandate or was there an element of state policy involved in making that decision?

MR. RUSSO: That was a state policy decision. There was no mandate to participate in that program because it is an optional program. The ICF/MR is not a mandated federal requirement for medicaid. It is an optional state program.

SENATOR HAMILTON: Does that come at all under your jurisdiction or is that under the DMR?

MR. RUSSO: Well, really, the administration and operation is under the Division of Mental Retardation. The flow of funds revolves through the medicaid program in order to generate the federal matches.

SENATOR HAMILTON: How many people are affected by the ICF/MR as we've implemented it now?

MR. RUSSO: All of the persons in all of the state schools are affected and the schools are affected in some way. I believe there are about 8,000 persons, in total in all of the state schools. But, not all individuals are eligible for that program. There are a portion of persons in the state schools for the mentally retarded who are not eligible.

SENATOR HAMILTON: What was the total number?

MR. RUSSO: Approximately, 8,000, to my knowledge.

SENATOR HAMILTON: This is an unfair question to put to you, but I'm going to put it anyway. Can you outline for me and for the benefit of anybody else who is interested the considerations that went into the expenditure of $40 million state dollars for 8,000 people in the ICF/MR program as contrasted with $20 million or $30 million, depending on whether you are looking at a $40 or $60 million total cost for a medically needy program, for some 90,000 people?

MR. RUSSO: Well, I think that the ICF/MR program has been a tremendous benefit to the state schools for the mentally retarded. It has been the means of upgrading staff, obtaining additional staff, of upgrading services to a level that

is considered by everyone to be,on a federal standard,to be acceptable care and I think, in that respect, there have been tremendous benefits. As a matter of priorities, if you are going to ask, are those benefits more important than the medically needy program and the benefits of the medically needy program, I think those are decisions that are policy decisions made by someone actually beyond myself.

SENATOR HAMILTON: Well, I'm sure of that and that's why it was probably unfair to ask you. The Legislature, after all, appropriated money for ICF/MR with some pushing, undoubtedly, from your Department and from the Governor. But, I suspect you could be the one to articulate some tremendous, potential benefits from the medically needy program in terms of people being assured of the health care that they need, of not being driven into debt and despair, and for the relative improvement of the fiscal posture of, at least, our urban hospitals and, I suspect, more than our urban hospitals, and affecting a whole lot more people than the ICF/MR. No doubt, they are difficult choices. I am being unfair to you and I am really thinking out loud and you helping me to think it through.

You have heard some of our testimony today and you've heard what has been said about the probable impact on the hospitals that are in financial difficulty were we to go to a reasonably expansive medically needy program, one that would cost somewhere in the upper ranges of the numbers that we have talked about. What do you think the situation will be between the combination of a medically needy program and 446?

MR. RUSSO: Well, actually, I think the medically needy program, again, that would be one of the offsets, I think. The persons who would qualify under the medically needy program, probably, now represent some of the persons who are in hospitals under the indigent category and are developing some of the bad debts that the hospitals have to pick up. Now, those bad debts are, obviously, being passed on to the various payers in the DRG program. The hospitals that are not in the DRG program, of course, are not getting the benefit of the broad base pickup of those costs and they still have the problem of making up those bad debts. But, eventually, all hospitals will be in DRG.

SENATOR HAMILTON: Can I stop you there for a minute, Tom? Go ahead. You finish your train of thought and I'll come back to this.

MR. RUSSO: I think that there would be a tradeoff that medicaid would be paying the hospitals for some portion of the patients now who are developing the indigent bad debt costs. That, in turn, would relieve the hospitals and would reduce, somewhat, I would think, and I'm not the DRG expert, but would reduce, somewhat, the rate structure under DRG. Now, how much that would be, I really don't know. But, there would be some tradeoff.

SENATOR HAMILTON: Do you think that 446 alone is going to get the urban hospitals out of trouble?

MR. RUSSO: Well, under DRG, theoretically, it should. If the total cost of the indigent care and bad debt are in the reimbursement rate and that reimbursement rate is spread over all payers of services, it should.

SENATOR HAMILTON: Then--and this is what I started to interrupt you for--and you're not the DRG person and I recognize that--why is DRG essential for the recouping of bad debts when the legislation never mentioned DRG and it was never mentioned in the process of developing 446? Did we not say that the rate reimbursement, regardless of whether it is DRG or something else, would consider, as an element, bad debts?

MR. RUSSO: My understanding, and again, I think you should probably be speaking to the Health Department, which developed the program, but my understanding is that, and you are correct that DRG is not an essential part of 446 and is not part of the legislation, but I think what happened, the Health Department utilized the DRG concept as a method and means of implementing the provisions contained in S-446.

SENATOR HAMILTON: Well, then, why should the urban hospitals who are being handled under DRG be the only ones who are now beginning to get some relief with respect to their bad debt situation?

MR. RUSSO: Well, the only way I could answer that, Senator, is that it is a phased in program and eventually, all hospitals will benefit by it.

SENATOR HAMILTON: I understand the phasing, but I don't understand-- I thought you said that the phase-in is working only with respect to the hospitals that are being treated under DRG, whereas the statute, as I recall it, included bad debts as an element of reimbursement, regardless of whether it was DRG or the old system.

MR. RUSSO: I think I would have to defer that question to someone else.

SENATOR HAMILTON: Okay. You have shown a great deal of courage up to now. Maybe that was wisdom as well as courage. There is no point in paying for someone else's sins if you don't have to. Is your department, at present, developing any particular models for the medically needy program or supporting any pending legislation with respect to that area?

MR. RUSSO: In the study that I had previously mentioned, which was done by the Department, we had developed several options or alternates within that study. I believe we did three or four different options with different benefit coverage and different costs. So, there were several packages that you could look at and weigh one against the other in terms of cost and benefit coverage.

SENATOR HAMILTON: But, there is no specific pending legislation that you are working on?

MR. RUSSO: There is no specific pending legislation, that I know of, at the present time.

SENATOR HAMILTON: So that I am fair to the private sector, to whom I put this question at the outset, within what time frame might we be able to get those options and the other data that we talked about?

MR. RUSSO: I could give you a copy of the study tomorrow.

SENATOR HAMILTON: You are well acquainted with Mrs. Seel?

MR. RUSSO: She may even have a copy of it. I'm not sure.

SENATOR HAMILTON: It need not be tomorrow, but I'll take that as a general expression of the kind of time frame and I appreciate it very much and I appreciate both of your assistants who were here.

MR. RUSSO: I have the study here. All I have to do is copy it.

SENATOR HAMILTON: Thank you. I hope we'll be able to call on you for help as we proceed.

MR. RUSSO: You may at any time, Senator.

SENATOR HAMILTON: Thank you very much.

MR. RUSSO: Thank you.

SENATOR HAMILTON: Ms. JoAnne Chasnow of the New Jersey Medically Needy Coalition?

J O A N N E C H A S N O W: Good day. I appreciate the opportunity to speak with you on one of the most critical issues today, health insurance coverage for New Jersey residents.

I am a bit disappointed that there is not more of your sub-committee with you, but hopefully--

SENATOR HAMILTON: Let me say this. The members of the sub-committee are the members of the full committee and while they may not be here today, they will have the transcript and they are--and I'll brag on them for a minute and not myself--among the most hard working members of the Legislature that we have and I can assure you that the fact that they are not physically present indicates no disinterest in the subject matter. First of all, Senator Hagedorn has carried bills in the area and the other members of the committee, from conversations that I've had with them, I know are very interested. I don't think you have drawn a conclusion, but I caution you, don't draw a conclusion about their interest.

MS. CHASNOW: Fine. I have not drawn any conclusions. The Senate sub-committee is undertaking a massive project by attempting to deal with, at least, one of the major problems within the health care delivery system and I commend you.

I am JoAnne Chasnow, Chairperson of the New Jersey Medically Needy Coalition and member of the Central Jersey Health Planning Agency, HSA 4, and a member of the New Jersey Human Services Coalition.

There are three factors which are having a great impact on the extremely high and so often inaccessible cost of health insurance, which I would like to discuss today. To adequately discuss health insurance coverage without discussion of its high price tag would seem to be not addressing the central issue for, if health insurance were within financial reach of every citizen, there would, perhaps, be no problem.

The first factor is the cost of providing care to the medically indigent or the medically needy community. There are several problems inherent in a system where tens of thousands of people are not receiving medical care coverage. Firstly, these people are not receiving any kind of primary care and will, almost always, wait until a crisis situation arises. Often times, if a disease can be identified early, it will be far less costly, both financially and psychologically, to obtain a cure. But, because this indigent population has no coverage, they end up hospitalized in a crisis situation, which could have been averted. There is, additionally, a highly inappropriate use of cost emergency room facilities by this group of people who don't know where else to turn. They use the emergency room for children's colds, for syphylis tests, as well as other medical problems which would be much more efficiently and cost effectively dealt with through primary care, rather than have the indigent costs passed on with an S-446 to the private payers. A solution to, at least, part of this problem is the medically needy program.

I will very briefly describe the program to you, with additions as far as what information you have already received. Many of the figures that I'm dealing with are from the Department of Human Services. The program would provide approximately 87,000 medically indigent people with comprehensive health care. 46,000 are aged and disabled. 41,000 are AFDC, Aid to Families with Dependent Children, who are otherwise eligible for either SSI or AFDC, but slightly above the income eligibility guidelines for AFDC, with medicaid coverage. It is a program which presently operates in 33 states and territories, New Jersey being the only industrilized state without such a program. It is a program in which the Federal Government pays ½ the cost of the entire program.

There are certain guidelines. First of all, the Federal Government will cover 50% of the costs, only for those people that meet the requirements that I just specified and only if their income meets the federal income requirements of no greater than 133 1/3% of the AFDC payment level. However, the applicant can become eligible by spending down to 133 1/3% level. According to the federal medicaid law, a person whose income is in excess of 133 1/3% of the AFDC level could become eligible by applying their excess income, the income above the eligibility level to their medical costs. Beyond that, medicaid would take over.

Potential costs savings to the counties of up to $10 million, which is now being spent for hospitalization and medical care of the poor through NJS 44:5-11. The medically needy program encourages these residents to get primary and preventive care because these services would be covered. This reduces misuse of emergency room facilities, as well as complications from unattended health problems.

The cost of the medically needy program has a potential offset of $12.7 million, presently being spent within state funded health programs. The spend-down provision encourages partial co-payment responsibility for eligible people.

There is a reduction of hospital bad debts by covering costs of some indigents, therefore reducing costs to insurers and finally resulting in lower premiums. This also an incentive to low income working people, rather than encouraging them to quit their jobs to become welfare eligible.

I believe, also, that the federal guidelines on the medically needy program are such that the state can choose to provide a minimum of, at least, all five mandatory medicaid services or a combination of any seven medicaid services up to the comprehensive, complete medicaid package.

The second issue, which I wish to discuss today, has to do with the lack of emphasis on prevention. The health insurance industry, which we are discussing today, is not health insurance at all, but disease insurance. I did not hear mentioned from the gentleman from Prudential of their involvement with home health or open enrollment, as I did from the gentleman from Blue Cross-Blue Shield. I have not heard mentioned from anyone today, except Dr. Vladeck, the issue of health promotion. Neither Blue Cross nor Prudential mentioned inclusion of regular physician checkups in their plans. Our system is crisis oriented, which is one of our largest problems. We must promote primary care. We must make use of all services and qualified personnel within the health care delivery system. There is an inadequate number of physicians who accept medicaid and the family clinics, at least within urban areas, are not meeting the demand, which is at their door. We must make use of the highly qualified, non-physician providers, the nurse practitioners, the physicians assistants and the certified nurse midwives to provide health care, not disease care, to the people who are crying for their help. Dr. Vladeck mentioned prevention and I believe in his committment. Yet, when we are viewing the perinatal designation plan for a HSA 4, I read about the regionalization of services to adequately and efficiently deliver high quality health care, especially to high risk mothers and children. I commend the design of regionalization, but, unfortunately, there was no mention or pre-natal nutrition, the idea of reducing the number of high-risk births which are occuring, but only how to deal with this condition once it was present. We must shift some of our priorities to reducing disease, rather than just curing it.

Although the HMO's seem to be taking several steps in a good direction toward primary care, they, as I have recently found out, are not meeting any responsibility toward the medically indigent community, my first general area of concern.

The third issue is the issue of regionalization. I believe that, as the state regionalizing its high technology, perinatal services, other high technology services could and should also be regionalized. It is a very expensive proposition for each hospital to maintain its own machinery, which is identical to the hospital across town. Regionalization of services would reduce costs and increase cooperation and communication between hospitals.

I thank you for the time to testify today and any additional assistance that I can be to you, please don't hesitate to let me know.

SENATOR HAMILTON: Thank you very much. I assume that Mrs. Seel has an address where you can be reached. I know it is or was in Highland Park, but I assume that she has a mailing address and so forth.

MS. CHASNOW: I could provide her with that.

SENATOR HAMILTON: Let me ask you one question, if I can, please. You heard the figures that Mr. Russo just gave us from the Division of Medical Assistance.

MS. CHASNOW: Yes.

SENATOR HAMILTON: Recognizing that you don't have access to all the data that he does, do you suggest to us any substantially different kinds of numbers for implementing a variety of medically needy programs. I think his range is from $15 million to about $50 million. Do you concur or do you put any kind of differ estimate on that?

MS. CHASNOW: The figures that I used when I testified to the Joint Appropriations Committee were given to me by the Department of Human Services. The figures which I used specifically in my testimony had to deal with a program of comprehensive care, but for nursing homes, which included--the cost was $59.6 million complete, so that half of that share would state, with reductions by cost savings of up to $12.7 million from other programs. I am at a point right now where I am receiving different figures from the Department of Health and I think it would be fairly deceptive for me to sit here before you and say that I am sure that those are the figures. I am going to be as part of the Medically Needy Coalition and the Coalition is going to be doing some research and meeting with the Department of Health , as well as the Department of Human services, giving the figures that we get to other members of the state for some assistance in economic clarification of cost analysis.

SENATOR HAMILTON: So, what I understand you to say, basically, is that you don't endorse the numbers that you have, which you got from the Department of Human Services, but you are accepting them and not quarreling with them, at least not at the present time.

MS. CHASNOW: I'll accept that.

SENATOR HAMILTON: If you could, within the next few days, could you give us a breakdown of that $12.7 million that you gave us? We would appreciate it.

MS. CHASNOW: Sure.

SENATOR HAMILTON: Thank you very much.

MS. CHASNOW: Thank you.

SENATOR HAMILTON: Mr. Pat Logue, New Jersey Hospital Association?

P A T R I C K L O G U E: Thank you, Senator.

I am Patrick Logue, Director of New Jersey Legislative Affairs for the New Jersey Hospital Association. I appreciate the opportunity to appear before the Subcommittee today to present the Association's comments concerning the scope and extent of health insurance coverage for New Jersey residents.

Before I begin my discussion of this matter, I would like to give you a little further background on the level of services provided by our hospitals to the citizens of New Jersey. For 1978, the latest year for which complete data are available, New Jersey's hospitals recorded admissions of 1.08 million patients with an average daily census of 35,386 patients. Thus 1 of every 7 residents is admitted to our hospitals each year with over 35,000 patients in hospital beds on any given day. On the outpatient side, 7.3 million outpatient visits occurred in 1978 with 2.6 million of these classified as emergency visits. Eighty-nine thousand babies were delivered and 548,000 surgical operations were performed. Total hospital expenses were approximately $2 billion with adjusted per inpatient day expenses in community hospitals of $172 a day. A total of 98,000 personnel were employed in 139 institutions. Of the 139 licensed hospitals in this State, 104 were non-federal, short-term general, or community hospitals.

These hospitals have traditionally treated all persons who presented themselves, regardless of whether they had health insurance or not. In effect, those patients who could afford to pay for their own treatment paid a little more to cover the costs of treating those who could not. Bills were adjusted on the basis of ability to pay and no one was turned away.

With the advent of Medicare and Medicaid in 1965, hospitals were reimbursed by the federal government for the care of eligible elderly and poor patients on a cost basis according to the "reasonable cost" of providing services covered by the programs. Allowable costs under the Medicare principles of reimbursement include both direct and indirect patient care costs, but specifically exclude bad debts and charity care. In other words, Medicare and Medicaid have not reimbursed hospitals for their share of those costs attributed to accounts that cannot be collected because patients are either unwilling or unable to pay for services that have been provided. Also, Blue Cross has not reimbursed hospitals for its share of uncompensated care. Thus under federal and state regulated reasonable cost reimbursement systems, the amount of uncompensated care has gone unreimbursed. This, of course, has resulted in a financial loss to hospitals. They have attempted to recover this loss by raising charges to other payors, so-called charge paying patients, to cover these losses. Thus, in years past, commercial insurors and charge paying patients have subsidized federal and state controlled health insurance plans for those costs associated with indigent care and bad debts.

A critical problem has arisen in many communities where hospitals have not had sufficient charge paying patients to offset these losses. These hospitals are, in many cases, the sole source of medical care for the residents of the inner cities. Their emergency departments and clinics often serve as the family physician for these residents, as we have already heard discussed today.

To give you an idea of the scope of uncompensated care provided, the 26 so-called DRG hospitals, which are a representative sample of the hospitals across the State, reported 1978 costs of uncompensated care for both inpatients and outpatients of $31 million. For 1980, using the State's inflation factor of 9 percent

a year for DRG hospital expenses, the total uncompensated care amount is $36 million.

Extrapolation of these figures statewide shows an annual loss to community hospitals of $112 million in 1978 dollars and $132 million in 1980 dollars for uncompensated care. These figures give an approximate idea of the scope of hospital care provided to people who apparently do not have adequate health insurance coverage to pay for services they receive in the hospital. This total estimated amount of $112 million in uncompensated care represented 6 percent of the $2 billion in total expenditures incurred by our industry in behalf of 1 million patients in 1978. This, of course, was one of the major issues that led to the passage of S-446 in 1978. With the enactment of that bill, the Health Care Facilities Planning Act was amended to require the cost of indigent care and bad debts to be included in the Hospital Rate-Setting Commission established payment rate for hospitals.

These costs are to be spread among all payors, including Blue Cross, Medicaid and Medicare, and hopefully this provision will remove the financial stress on certain hospitals created by this lack of coverage of the medically indigent portion of our citizens.

One other related factor in this discussion on the level of coverage for citizens who cannot afford to purchase their own health insurance has to do with assistance from county governments to community hospitals for indigent care. Under Title 44 of the Revised Statutes, most counties have made contributions to hospitals to cover a portion of the cost of treating indigent residents. Such contributions totalled $10.2 million in 1977. From there we see a steady decline in assistance to a budgeted figure of $8.36 million for 1980. This is an 18 percent drop in assistance statewide while in some counties assistance has stopped altogether or dropped at a much more drastic rate. I intended to attach a table. I see from a copy of my statement that it is not attached. I will be glad to furnish a copy of a table which shows county by county the assistance. Coupled with present day inflation and an increasing number of indigent patients requiring medical treatment, this reduction in county assistance to the hospitals has further exascerbated the problem of coverage for the medically indigent citizens of our state. Withdrawal of county assistance to hospitals already in the DRG system means those indigent care costs formerly covered by the counties will now be added to the rates of Blue Cross and the other payors. Withdrawal of county assistance to non-DRG hospitals could lead to a reduction in services or a corresponding increase in hospital charges to paying patients. In either case, there is an inequity. It is clearly inequitable for insured patients alone to pay for hospital care of the poor. Such indigent care should be the responsibility of all citizens and, in our opinion, financed through general state revenues.

I would like to conclude by bringing one more issue to the attention of this Subcommittee. That has to do with coverage under the state Medicaid program. In particular, I refer to Medicaid coverage of outpatient hospital services. I will not belabor the series of events surrounding the Department of Human Services' recent cutback in outpatient reimbursement and the subsequent reinstatement of this outpatient funding by the Legislature in this year's budget. Our major concern is that we will soon be faced with yet another budget crisis in Medicaid funding which will again jeopardize services for program recipients. From a public policy standpoint, it makes no sense, in our opinion, for the state to reduce coverage for necessary Medicaid outpatient services; and by reducing reimbursement for

covered services by 40 percent, the Department was certainly threatening the level of coverage that could be provided. Of all places to make budget cuts, outpatient hospital services should have been among the last. These are services through hospital emergency departments and clinics that in many cases are the sole source of medical care to which the poor have access. In addition, outpatient services are less expensive than inpatient care and should be encouraged whenever medically possible as an alternative to inpatient care.

The State has a responsibility to make the Medicaid program fiscally sound, just as any private insuror has a responsibility for fiscal security to its insured. The constant crises we seem to live with in Medicaid and other programs of the Department of Human Services threaten the existing level of services covered by Medicaid. Again, is it fair for privately insured patients to subsidize the State Medicaid program to pay for services provided to the poor but no longer reimbursed by Medicaid because of a budgetary shortfall? It is time for the Legislature, in our opinion, to meet this problem head on and either begin to provide the necessary funds to operate the program reasonably, to seek additional federal funding of the program, or to revamp the entire scope of the program.

I have attempted to point out the degree of care our hospitals provide to the poor and others that is uncovered through regular insurance coverage, both private and government sponsored. Whether the DRG payment experiment alleviates this problem remains to be seen. If it does not, we will have a serious public policy decision to make as to the future care of those who do not qualify for or cannot afford present health insurance coverage.

Thank you again for the opportunity to appear.

SENATOR HAMILTON: Thank you, Pat. Perhaps because it is late in the day, I have only one or two questions; but I would like to put them to you. I read you as saying, your hope - and perhaps your expectation - is that the problems with the medically needy are going to be the hospitals' problems and will be met in substantial measure by the provisions of 446, spreading those costs among the various classes of payors.

MR. LOGUE: Senator, I think you made an excellent comment earlier. I believe it was to Tom Russo. As far as 446 goes, yes, I agree with you. I think the law the way it was drafted would take care of that problem. Whether or not the particular method that is being used to reimburse under 446 will alleviate the problem remains to be seen. Initially, I would say that it is fair to say that the 26, and the urbans that are in the 26, are seeing an initial infusion of cash, which is making their lives a little bit better these days. But there is going to be a final reconciliation like a final Judgment Day that is going to come. We will not know until that day - and that is next year - whether or not the hospitals or the bottom line is going to come out as positive as it looks now.

SENATOR HAMILTON: At this point, you don't see the need for any direct infusion of funds through a State aid program to urban county hospitals or urban counties that have general purpose hospitals - anything of that kind?

MR. LOGUE: If the funds were available, I certainly would not want to discourage any sort of a grant program like that.

SENATOR HAMILTON: Nobody who comes before the Legislature ever says they don't need money.

MR. LOGUE: That's right.

SENATOR HAMILTON: Are you banging on the table and saying you need something at this point? I think you are saying no.

MR. LOGUE: I think that the federal government is embarking, HCFA now is embarking, on an infusion program of its own right now, a very speed-up sort of affair to try to get some Medicare money into any really critically fiscally hurt hospitals.

I think that 446 laid the groundwork for how the problem should be dealt with. I don't think that a one-time grant program is a way to deal with this problem. We have to build a system which provides a sound fiscal reimbursement. And I agree with you.

SENATOR HAMILTON: I was not suggesting a one-time grant program. Nevertheless, I think I understand your present position and you are free to change it. And I am sure you are going to monitor what we are doing as time goes by.

Let talk a little bit more about the DRG. Is your recollection - and I don't have the statute in front of me - the same as mine that that bad debt recapture was intended to be for all hospitals who are being paid by any method of reimbursement?

MR. LOGUE: That is my understanding.

SENATOR HAMILTON: Is not that the way it is being done now? Everybody has pointed to the DRG hospitals and said, okay, it is working that way. What is happening with the non-DRG hospitals?

MR. LOGUE: They are in the same boat they were before. Nothing has happened to really substantially change their reimbursement. They are still being reimbursed on the old share system of reimbursement. And until they come on DRG --- There are 26 now and only a portion of those are inner-city. Forty more come on in January and the balance the following January.

SENATOR HAMILTON: There was a time, maybe a couple of times - now is not one of them - when I understood "share." Why under the share reimbursement system are bad debts not a factor at this point?

MR. LOGUE: Historically, as I said, Blue Cross has argued that it doesn't have any bad debts, that it pays its bills. And the State, under share, has not recognized indigency; nor has Medicaid nor has Medicare recognized indigency and bad debt or uncompensated care as a reasonable element of reimbursement. They simply have said, we will not pay for it.

SENATOR HAMILTON: How much could the State of New Jersey change on its own to assist the non-DRG hospitals at this point in time?

MR. LOGUE: Well, the State has the option at any time it chooses. Under 446, the Department of Health had the option upon enactment to adjust the existing payment method to cover uncompensated care. It could have been done under the existing share system with the modification.

SENATOR HAMILTON: Has anybody hollered that they did not?

MR. LOGUE: We have tried to, yes, but not very successfully. What we have urged is that even now under the DRG system where the institutions that are on the system presently are being reimbursed, at least by Blue Cross, on a per case basis, that you could still pay on the basis of controlled charges. Initially, you could bill on the basis of controlled charges, and then, at the end of the year, have your final settlement on the basis of the DRG.

SENATOR HAMILTON: I think I had better read some more and talk some more before I talk to you more because it sounds to me like you are up here (indicating) and I am down here (indicating) trying to understand that. But I will follow through on it.

MR. LOGUE: I would be glad to discuss it further with you at any time.

SENATOR HAMILTON: Thank you very much.

Mrs. Glenna Slattery, New Jersey Nurses Association.

G L E N N A S L A T T E R Y: My name is Glenna Slattery. I represent the New Jersey State Nurses Association. We are pleased to be able to share with you some of our views. It is nice to be close to the last because practically everything I wanted to say has already been said. I am also working under a grave handicap here. I can't read my own writing.

SENATOR HAMILTON: That is a serious problem.

MS. SLATTERY: Haste makes waste.

One lady addressed the misnomer of health care. It is indeed a misnomer. As I read your memo, you are looking for scope and extent of health insurance. You are asking for input from the providers of health care and you are interested in the containment of health care costs. But in actual fact, everything that you have heard today has been aimed at sick care. From the Association's standpoint, one of our problems with the entire delivery system as it stands now is that it is not a health care system. It is a sick care system. The gate for entrance into that system is guarded by the doctor. You cannot come into a hospital except on doctor's referral and you don't go out except by his discharge. You do not get into a skilled facility, rehab hospital, or whatever, without a physician taking you there and, again, bringing you out.

We have a variety of problems with that. For instance, in the acuity of care system, if you do get sick, regardless of who pays what to whom, whether it is Medicare or Medicaid or the private carriers, whatever the fiduciary mechanism is, the fact of the matter is that money is changing hands. Someone is giving someone else a dollar for a service provided. One of the major factors in the provision of sick care is the nursing care that you get. Most hospitals - I could be corrected statistically because my numbers are relatively old --- but most hospitals have about 10 percent of their admissions that come to them for the diagnostic workup that the machines provide. The other 90 percent of the people who walk through those doors are there because there is something wrong with their physiology. There is some pathology present that a physician feels needs 24-hours-a-day, 7-days-a-week monitoring. And it is my people that monitor you. We put you to bed. We give you your baths. We do, as Mr. Russo said, care and treatment ordered by the physician to be provided by others. Well, the most significant "other" is the nurse. In New Jersey, if you get less ---

SENATOR HAMILTON: Is that "significant other" one of the modern in-phrases that I have heard used?

MS. SLATTERY: I always think it means your mother and dad, myself.

When the dollar changes hands, you are paying for the care that my people give you. If you get less than your dollar value, it is not necessarily totally nursing's fault. For instance, in the share system that you are speaking of, the budgeting mechanism there is cost centers. And any hospital that looks at its cost centers will always find the largest cost center is nursing. You will correct me if I am wrong? I am not wrong. In the hospitals' voluntary effort - and I hold no umbrage with their intent; I have a problem with the mechanism they employ - they reduce the highest cost center. In that cost center under "share" were the hotel charges, the dietary charges, the laundry charges. They were all lumped under the nursing budget. Those are very significant charges in themselves.

So, when the hospital decided that they should save money by reducing

costs, they reduced costs by attrition in nursing personnel. And when you went in a hospital, you said, "I never see a nurse anymore," or "the nurse didn't give me good care like five years ago." Well, you know one person can only be one place.

We feel that in the State of New Jersey, you already have in existence a highly educated, well prepared, independently licensed, independently accountable group of practitioners. The last Board of Nursing statistics in July 1980 indicated there are 75,000 nurses licensed to practice in the State of New Jersey. We have approximately 35,000 practicing. Part of the reason why they don't practice is money. Part of the reason is part of the social climate in which many women don't view their careers as a life-time occupation. It is merely a transitory occupation until they get married and have children. But part of the reason - and this has been borne out by recent studies nationally - is that nurses leave nursing from frustration because they are educated to practice in a certain way, but the confines of the system don't allow them to provide the care that they are will equipped educationally to provide.

The other prong of the delivery system, whether it is health or sick, is again the point that the young woman made, and that is the health maintenance aspect. But the independent functions of the New Jersey Nurse Practice Act which allows counselling, teaching, monitoring, and early detection of minor problems could go a long way to alleviate, certainly within the inner cities, the problem of no care. It is not so much that they don't have access to the system. The problem is that they have to get sick to get in; and, when they get in, there are not enough physicians there to do the small pathology involved.

This Committee should give serious thought to implementation of a program that would produce a greater cost effective delivery of quality care, which could be obtained by the proper utilization of your nursing population that is underutilized in acute care settings by freeing them from the budgetary constraints of the total cost center, eliminating the hotel charges. It is my understanding - and Pat knows more about this than I do - in the DRG project, there was a nursing screening committee, which was to work on the acuity of care. If you have two young women, both with appendicitis, admitted on the same diagnosis, the diagnosis is correct and they go to surgery, if they come back to me and one young lady is fine, I can tell her to wait until her mother comes in; but if the other young lady has peritonitis, that is a whole different nursing problem. I have to make a number of independent judgments on that. I could assign one nurse to that young girl for at least three days; whereas, the other girl with the same admitting diagnosis, really other than to be sure that she has the few things she needs, I don't have to bother with.

If you utilized the nursing population that you have in acute care and gave them a certain amount of autonomy and control over practice rather than have them practice by administrative decree, via the memo, and if out in the community you utilized those nurses who are educated at the Master's level of subspecialities, they could provide a monitoring mechanism for the health of the population, specifically within the inner cities. Whenever my people have attempted to do that, there has been a chilling effect brought to them by the physicians who are determined that these young women are practicing medicine. Well, they are not. But as the physician's practice has expanded, in that he can now take your brain tumor out and 50 years ago you died with it, so have all of the ancilliary people who practice in the health

care delivery system had their practice advance. This entire delivery system has completely ignored, as it stands today, the largest group of primary health care providers - and primary care is that first person who touches you - as well as the largest single entity within the entire delivery system's labor force. It has never been sought out for input and they have never been utilized to the level of their preparation. I think there is a variety of societal reasons for this which the mere fact that you are listening to me today would tell me that there must be some change in that fabric.

But, in any event, if you are looking for the cost efficient delivery of quality care, the maximum number of people, then you might give great attention to the greater utilization of your existing largest single provider. Thank you very much.

SENATOR HAMILTON: Thank you very much. I know that you speak with great conviction about what you said. I am sure that there are some avenues there. I know that one of our attendees today who did not sign up to speak is vitally interested in home health care. And I want to hear at some point in time about that prospect as well.

But it would help us in the future - and I address this now to you, Glenna, because you are with us --- Conceptually, I understand everything you said. If there are specific proposals that are now before the Legislature or have been in the past or are in the process of being developed, whether they are in bill form or not, it would be helpful to us to at least be able to review them. I give you no promise that we are going to embrace them. But to translate from the concept into the specific in terms of change A or change B, in rule, regulation or statute, would be helpful.

MS. SLATTERY: On that specifically, the Association had third-party reimbursement bills in last year which were opposed by the Prudential because they did not carry embodied within them the prerequisite that in order to utilize the mechanism you would have to come with a physician's referral. The Association took under consideration that recommendation and decided that in the light of the fiscal climate and the change, flux and transition of the whole health care delivery system, we would resubmit those bills - Senator Bedell was the sponsor - and they sit now in this body.

SENATOR HAMILTON: In the full I, H, & W Committee or are they elsewhere?

MS. SLATTERY: I believe they are assigned to the I, H, & W Committee. No, they are in the Labor Committee. I'm sorry.

But that would be an initiating mechanism. These were at the option of the insured. If you choose to have this for x number of dollars, you can have it. Right now in the State of New Jersey, I can think of one woman in particular who was reimbursed by a third-party mechanism without referral from a physician. She primarily deals in the family counselling of the leukemic child, either in preparation for the termination of the child or in ingratiating the child into the family. But she is reimbursed by a third-party payor and there is no physician referral.

There are bills of this nature in the Massachusetts Legislature and in Maryland.

SENATOR HAMILTON: What I am asking is that, to the extent that you can, you accumulate them and let us have them as part of the things that we will chew on.

MS. SLATTERY: I certainly will.

SENATOR HAMILTON: Thank you very much.

MS. SLATTERY: Thank you.

SENATOR HAMILTON: Mr. Leonard Koch, Associate Director of NJEA Research, and a very patient young man.

L E O N A R D K O C H: Senator, I guess you are pretty used to a day like this, but it is absolutely mind-boggling to me how you can look as fresh now as you did this morning when I saw you.

SENATOR HAMILTON: It is that way on the outside, but it is not that way on the inside.

MR. KOCH: I will try to go over my written statement and summarize it as we go along. The scope of conversation that I heard here this morning has been tremendous. What I plan to do - I guess unfortunately for your Committee - is broaden it even a little further.

I am Leonard Koch and I am Associate Director of NJEA Research. My partner, Morton Reinhart, and myself are responsible for NJEA's special services and retirement.

We have in the NJEA 110,000 members. Thirteen thousand of those members today are retired educators. The rest of the membership is made up of employees of the public schools throughout the State.

I come here this afternoon because of the problems that we see and have encountered with the State Health Benefits Program. The State Health Benefits Program is the health insurance program for 73 percent of the 591 school districts throughout the State, which means that we are talking about a large number of people. Four hundred and thirty-three school districts in all are participating. The program is governed by the State Health Benefits Commission, which is established by New Jersey Statute Title 52:14-17.2. It was opened up to political subdivisions in the State of New Jersey in 1964. The program was initiated for State employees in 1961.

The statute provides for broad basic health insurance coverage, including hospital care, medical-surgical, outpatient care benefits, substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of New Jersey "Blue Cross" and "Blue Shield" plans and major medical benefits. In order for the program to remain viable, it is essential that the State Health Benefits Commission have the authority and the flexibility to improve base-plan benefits as improvements become available through both Blue Cross and Blue Shield. The Commission has made proper and significant improvements up to 1977.

In 1975, the Commission improved the Blue Shield, Medical Surgical component by increasing coverage from the Blue Shield 500 Fee Program to the, at that time, new Blue Shield 750 Fee Program. This improvement in base-plan benefits gave the employer more value for their dollars spent in premiums due to the medical surgical plan "service benefits" provision, which states that participating physicians accept as payment in full that amount paid by Blue Shield for covered services for participants whose family income is below $12,000 in the 750 Fee Program, which is significantly above the former $7,500 threshold of the 500 Fee Program. In 1974-75, the average teacher salary was $12,618. In 1979-80, it is $17,159. The overall advantage to the plan is that these employees covered under this service benefit provision would not traditionally receive and be obligated to pay balanced bills from physicians for covered services. Balance billing of this nature has a direct impact on the cost for major medical since the covered person would

pass on additional costs to the major medical component of the Plan.

The problem that we have today has to do with the 14/20 Fee Program, which has been available for the last couple of years. The threshold for service benefits for family income is $20,000. As you can see, in the schools, the average teacher's salary is up around $12,000, going over $18,000. We are still at a point where moving to the 14/20 Fee Program will have a significant impact on the cost for our major medical coverage. I believe the longer we wait before we move into the 14/20 Fee Program, the more we are going to lose in dollar value spent on our premium for health care. The dilemma is that the Commission in response to a request we made back in May of 1978 has become extremely hesitant upon making any changes in the program which quote, unquote, "would cost any more dollars."

I mentioned in my written testimony that prior to 1977 the Commission made many different improvements. They are listed there. I didn't bother reading them.

If the Commission's attitude prevails in the future, which is spelled out in the quotation in the written testimony, where no changes are made any longer without either legislative action or without negotiations at the local level with the Board of Education, then the program as it exists for political subdivisions in the State of New Jersey is headed for doom. It's over because there is no way that the groups are going to maintain their participation in the State Health Benefits Program if the program doesn't keep up with the times.

The Commission in their reply to the NJEA has indicated that they will not make a move and has stated in their reply that the local boards of education that want to make improvements can make the improvements with the understanding that to do so they would have to drop out of the State Plan. I am concerned about that. I am concerned about it because it creates an attitude which suggests withdrawing from the program. And the thing that makes the program viable and smart - and I think it has been right ever since its inception in 1964 - is because it pools the experience of relatively small groups into one large pool. By pooling that experience, the overall cost on any one board of education or employer is not upset by a severe catasthropic health circumstance with any of its employees in a given year.

We believe this approach is counterproductive - that is the approach of the Commission - and one which will lead to certain failure of the program since it establishes the suggestion of withdrawal by participating groups.

We ask that this Committee reaffirm the legislative intent practiced by the Commission prior to 1977 and encourage it to make improvements in the base plan from time to time to keep the program current and competitive and on a sound financial base which means more value for each dollar spent.

To re-emphasize, what we are looking for here is for the Legislature in some way to give the Commission the message that they want the Commission to continue to act as they did prior to 1977 to keep that program viable.

In addition to broad basic benefits, the State Health Benefits Program includes major medical coverage underwritten by Prudential. In our opinion, improvements in the major medical component requires legislative action. This program has fixed annual and lifetime limits. In an inflationary economy, all programs with fixed limits require change in time to maintain the protection initially intended. We enthusiastically support S 1483, proposed legislation by you, Senator Hamilton, to eliminate the annual $25,000 maximum and increase the lifetime maximum to $1,000,000

for all covered employees, both active and retired. The current $100,000 and $20,000 lifetime maximum for active and retired participants, respectively, is no longer viewed as adequate protection by thousands of covered participants. Unfortunately, I was not here, but I understand Jim Cottingham made that point very, very well in his presentation.

SENATOR HAMILTON: He certainly did.

MR. KOCH: Many of our members have purchased additional insurance under pressure by sales people playing on their fears that in these inflationary times, their coverage is inadequate under the State Plan. The well publicized purchasing of expensive individual insurance plans which pay little in return is a problem to which our members are not immune. An increase in these maximums will go a long way in putting to rest this perceived need and in ending the heavy pressure being applied to members to purchase additional insurance.

For the purpose of encouraging new groups to participate in the State Health Benefits Program, we suggest that it allow new participating employers to enroll their employees in the program and be permitted to also offer this coverage to their retired employees, at least to the extent that they now offer coverage to these employees through programs that they have established on the local level. Many of these political subdivisions are cut out from the opportunity of participating in the program, since they have an obligation under contract to cover many of their present retirees. This privilege would require enabling legislation.

To help the Committee in its study of the State Health Benefits Program, I distributed to you copies of the NJEA Research Circular A9-61 of March 1980. This gives you a complete breakdown, school district by school district, in each county, as to the health insurance coverages that they have, whether it be through the State plan or some other carrier, Blue Cross-Blue Shield, or private plan. It shows you the rates that they are paying. It shows you how much is being paid by the employee and the employee's dependents. It also gets into research on other health insurance coverages that some of our members have through their employment in the various school districts.

I also attached to my written testimony a breakdown of the rates of the State Health Benefits Program broken down by coverage from Blue Cross, Blue Shield and Major Medical since 1972. I think if the Committee reviews those rates, they will get a good idea as to where the inflationary part of the program has existed and where improvements in the program may be effected with little change in overall cost. Going back to the theme that I sincerely believe that changes can be made to give us more value for our dollars spent, the note at the bottom of the rate sheet indicates from a non-actuarial perspective, because I am not an actuary, an estimate of what the cost would be, for instance, in moving the program from the 750 Fee Schedule to the 14/20 Fee Schedule, which I believe would have considerable savings on the major medical. But I am not able to determine exactly what that would be. (See page 11X for written statement submitted by Mr. Koch.)

SENATOR HAMILTON: Leonard, thank you very much for several things: first of all, for your testimony; the data you furnished us; for your expression of support for 1483; and, generally, your concern in this subject for certainly your own members and, I assume, for the State as well.

Let me ask you just one question. The coverage that is afforded to NJEA members - and I will ask you only about them at this point - is that contributory in any way?

MR. KOCH: In most school districts, it is paid 100 percent by the employer. As the publication that I have distributed to you will show, there are some school districts where there is a sharing of costs. Now, for the State plan, the law requires that the employer pay the full cost for all employees. Then it is negotiable as to whether or not the employer will pay the full cost for the dependents.

SENATOR HAMILTON: But with respect to your NJEA members, everybody has access to the same plan and whether or not it is contributory and the extent to which it is contributory if it is at all is dependent upon local collective bargaining. Is that what you said?

MR. KOCH: Our members, Senator Hamilton, come from each of the school districts and each of the school districts negotiates its individual programs.

SENATOR HAMILTON: That is what I meant.

MR. KOCH: So there is no one plan for all members, although, as I indicated, 73 percent of our school districts participate in the State Health Benefits Program, which means there are 433 school districts participating. Therefore, a significant portion of our members are participating in the program I was speaking about today.

SENATOR HAMILTON: Thank you very much. I assume we will be able to call upon you again.

MR. KOCH: Please do. This has been my pleasure.

SENATOR HAMILTON: I have the names of Mr. Ranahan from the Department of Labor and Industry and Mr. White from the Department of Insurance. I understood you were here to answer questions, if necessary. It will be necessary, but it isn't going to be necessary today. But we appreciate your attendance.

I don't have the name of anyone else. If I did, because of another commitment, I could not stay to hear you today.

I want to thank everybody who appeared for your participation - for your input. I think we are a long way from knowing where we are going. But I feel good about the start that we have made and I thank all of you for your participation in making me feel that way. Thank you very much.

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STATEMENT BY:

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before

The Subcommittee on Health Care Costs
Institutions, Health and Welfare
Senate of the State of New Jersey

September 4, 1980

Senator Hamilton, members of the Committee, my name is [illegible] Vlaleck. I am Assistant Commissioner for Health Planning and Resources Development of the New Jersey State Department of Health.

Let me begin by immediately conveying Commissioner Finley's strong personal regrets that she is unable to attend today's hearing. Dr. Finley, and indeed the entire Department, have a deep and abiding interest in the issues being addressed today. We are also extremely mindful of the excellent relationship the Department has had with this Committee over the last number of years, as best exemplified in the arduous but cooperative mutual work that resulted in passage of Senate Bill 446, (what we are now more formally referring to as Chapter 83 of the Laws of 1978) in 1978. However, Dr. Finley is at this time attending a meeting of the Health Care Administration Board, of which of course she is a member by statute, and she has asked me to extend her deepest personal regrets.

In her absence, I will attempt to very briefly summarize the Department's interest in the issues before this Committee today, and to provide you with the somewhat limited amount of information on which we are able to lay our hands. The Department is interested in the "scope and extent of health insurance coverage for New Jersey residents" for at least two reasons. Most obviously, under Chapter 83, we are now charged with the central responsibility for a program of health care cost containment in the State, one that at the same time

assure the access of all citizens to medical care of the highest standards of quality, effectiveness and efficiency. The nature of health insurance coverage, including not only who is covered but the kinds of services that are insured and the way in which insurers reimburse for services, are obviously central to any cost containment strategy. Since we have moved to implement Chapter 83, we have learned a great deal, not only about the patterns of medical indigency within the State but also about the characteristics of commercial and other forms of private health insurance coverage which, in the past, had lain entirely outside our jurisdiction. Put most simply, whereas in the past we were responsible for regulating the rates paid by just two major payors, (Blue Cross and Medicaid), we now are responsible for recommending to the Hospital Rate Setting Commission the rates that will be paid by literally hundreds of commercial insurance companies, self-insured health and welfare funds, HMOs, and even individuals. It has been quite a learning experience.

But on what is perhaps a more basic level, we are also deeply concerned about patterns of health insurance coverage because of our role as the Designated State Health Planning and Development Agency, in accordance with the National Health Planning and Resources Development Act and New Jersey's own Health Care Facilities Planning Act, (to which Chapter 83 was of course a series of amendments.)

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The first New Jersey State Health Plan, which was formally submitted from the Statewide Health Coordinating Council to Governor [illegible] earlier this year, and accepted by him, assigns a major priority to reform of the health insurance system in order to better encourage preventive and outpatient services, and to reduce the emphasis on acute inpatient care. As I'm sure you know, existing health insurance programs have often been criticized for their extensive and relatively generous coverage of the much more expensive acute hospital services while they tend to ignore more cost effective outpatient and preventive care. Since the major thrust of the State Health Plan is towards rationalizing a system which now overemphasizes tertiary, curative inpatient services, by developing a community based, regionalized system which emphasizes the maintenance of good health and the provision of preventive and primary services, health insurance reform necessarily flows from the logic of the entire planning process.

Given these broad interests, what can we tell you? In fact, we know distressingly little with any precision about the patterns of health insurance coverage in this State. What we can say with confidence consists largely of the following: First, if national estimates can be reasonably applied to New Jersey, roughly 90-95% of the population has some kind of insurance for hospital care. A considerable fraction of that number also has some form of major medical insurance, which does provide coverage for non-hospital

services after meeting a fixed deductible, and may provide substantial protection against catastrophic family expenses. Our best estimate is that roughly five percent of the State's population, something on the order of 350,000 persons, have no health insurance of any kind. We also would expect, if national proportions hold in New Jersey, that those without any form of health insurance coverage are disproportionately young.

We also know that in calendar 1979, New Jersey hospitals provided approximately $110 million worth of care to persons unable to pay for it themselves. About one-forth of that total was outpatient care, although we have reason to believe that there is substantial under-reporting of outpatient deficits due to the provision of care to people unable to pay. It should also be noted that out of that total of $110 million, roughly a third occurs at a single institution, the College Hospital and its predecessor, Martland, in Newark, and is now subsidized largely through the budget of the Department of Higher Education.

In 1979, State and local governments in New Jersey provided grants of approximately $50 million for care of the indigent in New Jersey hospitals. However, again, almost 70% of this total represents the Department of Higher Education's subsidy to the College Hospital. In toto, counties and municipalities in fiscal

year 1978 provided just over $106 million in government aid to health care institutions, but the overwhelming bulk of that went for the maintenance of county hospitals and homes. This sum primarily consisted of expenditures for mental health care. In addition to its subsidies to hospitals through the budget of the Department of Higher Education and the $6 million available to contract to public general hospitals, under the Public Hospital's Assistance Act, the State also expends approximately $40 million per year on the program of Pharmaceutical Assistance for the Aged, and about $3.5 million a year in its Maternal and Child Health Program. There are also, of course, substantial state expenditures for Mental Health services.

While Chapter 83 has directly addressed the problem of the impact of care for the uninsured and medically indigent on the fiscal stability of hospitals, by spreading the burden of charity care over all users of hospital services, it obviously cannot speak to the out-of-hospital services which are often those to which the low income and working class population has the most limited access. I refer here not only to out patient physician visits, but also to drug costs for the nonelderly, dental and vision services, and most strinkingly, routine preventive and well-child visits for expectant mothers and young children, the single most cost effective forms of health care intervention, and those most seriously undersupplied in many parts of this State.

In sum, while the vast majority of New Jersey citizens enjoy very substantial insurance coverage for a broad range of health services, a small proportion, but very large number, of persons is entirely without health insurance coverage of any kind. A considerable fraction of the population also lacks insurance for all but inpatient hospital services, and thus for many of the most useful and cost effective preventive services.

If I could, I would like to conclude my remarks by briefly summarizing for you the actions the Health Department is taking, or will soon be undertaking, to begin to help address these shortcomings, notwithstanding the limits of our appropriate statutory mission and the more pressing and immediate limits of human and financial resources. First, in conjunction with the Sub-Committee on Access of the Plan Implementation Committee of the Statewide Health Coordinating Council, we are actively exploring the undertaking of what would be the first comprehensive Statewide survey on access to medical care. In this time of tight state budgets, there are not adequate funds within the Department's budget to undertake such a study on its own, but we are pursuing, and are confident of receiving, private financial and technical support which would permit us for the first time to create a base of current data from which we could draw substantially more informed conclusions about who is getting what kinds of health services in this State, and the reasons why those who aren't getting

needed services are not getting them. If our planning and then implementation for this effort proceeds on schedule, we would be able to report detailed results to you by next summer.

Second, in a rather different vein, the Department continues its active efforts to expand the availability of the option of enrollment in Health Maintenance Organizations to all New Jersey citizens. At the current time, the nine HMOs in the State of New Jersey enroll approximately 150,000 people, providing them with a substantially more comprehensive range of services, especially including outpatient and preventive care, than is customarily available under most health insurance contracts. While HMOs are clearly not for everyone, there is probably a substantial portion of the population that would find such alternative forms of health care coverage attractive if they were available in desirable settings at reasonable prices. Although substantial federal assistance is available, the creation and maintenance of a successful and financially self-supporting Health Maintenance Organization is an arduous and time consuming task. We have had our setbacks in this State. But HMO enrollment continues to grow, in some small part, we like to think, because of the Department's activity both in promotional and educational efforts and in the provision of technical assistance to both existing and planned HMOs. We are confident that the steady, if undramatic process of HMO building will continue in the coming future. In particular, we are eager to see extension of HMO availability

to those few areas of the State where HMOs are not now an option to citizens; we continue to work with the State Employees Health Benefits Commission to ensure that those covered by the State employees plan, which includes a large proportion of all public workers in local and county government as well as State government, are afforded an HMO option at reasonable and competitive prices. We will continue to explore with HMOs the development of new marketing techniques.

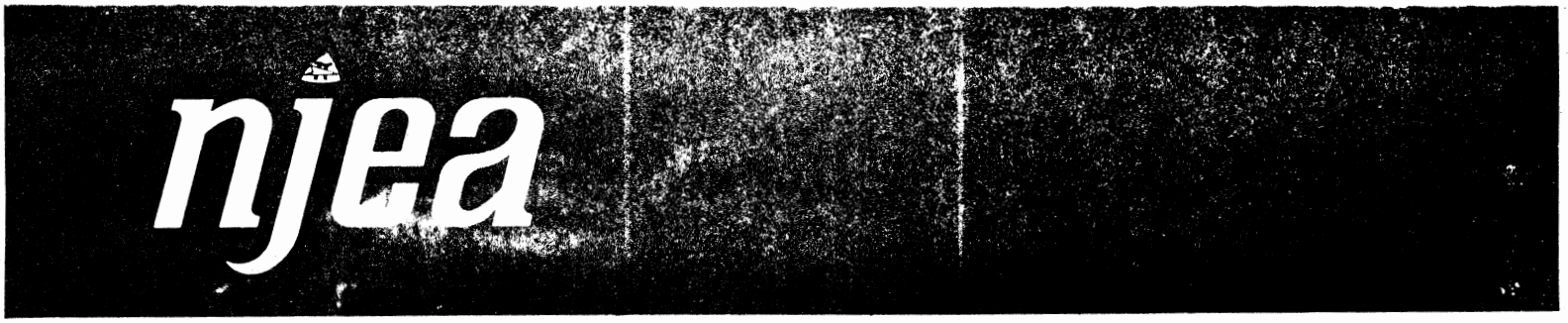
Third, but perhaps of greatest immediate interests to this Committee, we are working with the Department of Insurance, with the active support of the Governor's Counsel, to draft proposed health insurance reform legislation which would provide for a uniform minimum standard of benefit packages for all health insurance provided in the State. This would be directly in keeping with the priorities in the State Health Plan for an expansion of insurance coverage for ambulatory and preventive services of demonstrated cost effectiveness, and would also substantially ease the administrative burden on hospitals not to mention ourselves - involved in managing a rate setting system that applies to all payors in the context of the current crazy quilt pattern of insurance coverages. We hope to have completed drafting such legislation within the next month, at which time we will review it with the Department of Insurance and the Governor's Counsel before makint it public. We have already committed ourselves

to the insurance industry and other interested groups, as we happily commit ourselves to you now, to share such a draft at an early stage, in order to provide for the broadest degree of public discussion and informed input before submission of a formal legislative proposal. But we hope within the next 6 or 8 weeks to put on the public agenda the content of such a proposed law, which even if it engenders a considerable and lengthy period of debate, should at least focus that debate in a way that we would hope would be useful to the legislative process.

I should add that, in our very preliminary and, I would be the first to admit, vague discussions, we have received enthusiastic expressions of interest from the major health insurers in this State, all of whom have assured us of their interest in working together on such a proposal.

In light of the particularly noteworthy record of this Committee under Senator Scardino's Chairmanship, and especially in light of the promising beginning of this Sub-Committee, we are thus especially hopeful that over the next number of months we can begin a dialogue that will ultimately result in the shaping of new legislation that can be of the greatest benefit to all citizens of this State, particularly those who, because of gaps or shortcomings in existing health insurance plans, do not receive the sort of health care services that they need and could use.

We look forward to working with you and members of the Committee. I would of course be more than happy to answer any questions you might have at this point.



Statement by Leonard Koch, associate director of NJEA Research, before the Senate Institutions, Health and Welfare Subcommittee on September 4, 1980.

Mr. Chairman and members of the Senate Institutions, Health and Welfare Subcommittee on Health Care Costs, I am Leonard Koch, associate director of NJEA Research. Thank you for the opportunity to come before you to express our views in behalf of the New Jersey Education Association "to gather information concerning the scope and extent of health insurance coverage" for New Jersey school employees.

The New Jersey Education Association represents over 110,000 members. This number includes such certificated personnel as teachers, administrators, and faculty of higher education institutions. That number also includes support staff such as secretaries, bus drivers, cafeteria workers, custodians, and aides. Our membership also claims over 10,000 retired educators.

The State Health Benefits Program was established in 1961, initially covering state employees, and in 1964 was extended to include political subdivisions of the State of New Jersey, including public school districts. The Program is governed by New Jersey State Statute Title 52:14-17.2. The benefits under the Program have been liberalized several times since its inception. These liberalizations provided Rider J benefits,

increased major medical benefits, extended care facility, home care services, the elimination of the waiting period for 10-month employees who were on the job at the beginning of the contract year, upgrading of the surgical payment schedule from the 500 series to the 750 series, liberalization of benefits for mental, psychoneurotic or personality disorder in that expenses will be determined the same as for other covered disabilities under the major medical, and the Elective Surgery Second Opinion Program. Benefit improvements have been initiated either by act of the Commission, or the legislature as they became available.

Five hundred ninety-one of 595 school districts have complete or partially paid health insurance plans. One district does not have an employer-paid plan, and three districts are not applicable because they are not fully operating school systems.

Seventy-three percent (433) of the 591 districts are covered by the State Plan, a decrease of four districts over last year. The Blue Cross/Blue Shield is listed as the carrier in 21% (124) of the districts and the remaining 6% (34 districts) have various other carriers, such as Connecticut General, Travelers, etc.

The above is extracted from the NJEA Research Circular A9-61/ March 1980.

The statute provides for broad basic health insurance coverage including hospital, medical surgical, and out-patient care benefits substantially equivalent to those available on a group remittance basis to employees of the state and their dependents

under the subscription contracts of New Jersey "Blue Cross", "Blue Shield" plans and Major Medical benefits. In order for the program to remain viable, it is essential that the State Health Benefits Commission have the authority and the flexibility to improve base-plan benefits as improvements become available through both Blue Cross and Blue Shield. The Commission has made proper and significant improvement up to 1977.

In 1975, the Commission improved the Blue Shield, Medical Surgical component by increasing coverage from the Blue Shield 500 Fee Program to the at that time new Blue Shield 750 Fee Program. This improvement in base-plan benefits gave the employer more value for their dollars spent in premium due to the medical surgical plan "service benefits" provision which states that participating physicians accept as payment in full that amount paid by Blue Shield for covered services for participants whose family income is below $12,000 in the 750 fee program which is significantly above the former $7,500 threshold of the 500 fee program. In 1974-75, the average teacher salary was $12,618. In 1979-80, it was $17,159. The overall advantage to the plan is that these employees covered under this service benefit provision would not traditionally receive and be obligated to pay balanced bills from physicians for covered services. Balance billing of this nature has a direct impact on the cost for major medical since the covered person would pass on additional costs to the major medical component of the Plan.

We believe that it is imperative that the State Health Benefits Commission's authority to act on significant improvements in the base plan of the State Health Benefits Program be maintained and used by the Commission for the good of all without political overtones. The Commission, in recent years, has been extremely reluctant to make significant changes which, in our opinion, are vital to maintain high participation in the State Health Benefits Program by political subdivisions of the State of New Jersey.

In May of 1978, the New Jersey Education Association asked that the Commission act to adopt the Blue Shield 14/20 fee program which would improve the schedule of benefits and increase the service benefit threshold to $20,000 under family coverage. This change would have the effect of keeping the program current and impact positively on the major medical costs. The Commission's response to our request states:

> "While the Commission is sympathetic to the problem occasioned by rising medical care prices, resulting in lesser reimbursement under Blue Shield and increasing claims under the major medical provision, it does not believe that it can act to adopt any new series of Blue Shield reimbursements which would increase costs. More importantly, the Commission believes that it cannot do so because health benefits are negotiable. As such, if an organization negotiates a 14/20 Blue Shield schedule, and if that group is already participating in the State Health Benefits

> Program, the only opportunity for the change in benefits would be by withdrawal from the State system because that benefit is not provided for in the statute governing the State program. If legislation is enacted mandating 14/20 for participants in the State program, then it applies universally to all employers and employees and any group who is dissatisfied with the change can withdraw from the program and seek an alternative plan of health insurance."

We believe this approach is counter productive and one which will lead to certain failure of the program since it establishes a suggestion of withdrawal by participating groups. We ask that this committee reaffirm the legislative intent practiced by the Commission prior to 1977 and encourage it to make improvements in the base plan from time to time to keep the program current and competitive and on a sound financial base which means more value for each dollar spent.

In addition to broad basic benefits, the program includes major medical coverage underwritten by Prudential. In our opinion, improvements in the major medical component requires legislative action. This program has fixed annual and lifetime limits. In an inflationary economy, all programs with fixed limits require change in time to maintain the protection initially intended. We enthusiastically support S1483, proposed legislation by Senator William Hamilton to eliminate the annual $25,000

maximum and increase the lifetime maximum to $1,000,000 for all covered employees both active and retired. The current $100,000 and $20,000 lifetime maximum for active and retired participants respectively is no longer viewed as adequate protection by thousands of covered participants. Many of our members have purchased additional insurance under pressure by sales people playing on their fears that in these inflationary times, their coverage is inadequate under the State Plan. The well publicized purchasing of expensive individual insurance plans which pay little in return is a problem to which our members are not immune. An increase in these maximums will go a long way in putting to rest this perceived need and in ending the heavy pressure being applied to members to purchase additional insurance.

For the purpose of encouraging new groups to participate in the State Health Benefits Program, we suggest that it allow new participating employers to enroll their employees in the Program and be permitted to also offer this coverage to their retired employees, at least to the extent that they now offer coverage to these employees through programs that they have established on the local level. Many of these political subdivisions are cut out from the opportunity of participating in the program, since they have an obligation under contract to cover many of their present retirees. This privilege would require enabling legislation.

To help the Committee in its study of the State Health Benefits Program, you have been given the NJEA Research Circular A9-61 March 1980 Group Insurance Plans. Attached to my testimony is a breakdown on the rates of the State Health Benefits Plan since 1972.

Thank you.

STATE HEALTH BENEFITS RATES

BLUE CROSS BLUE SHIELD MAJOR MEDICAL

10 = Single 50 = Family

	1972	Blue Cross	% increase (decrease)	Blue Shield	% increase (decrease)	Major Medical	% increase (decrease)
	10	8.69		2.82		1.50	
	50	24.07		9.05		3.75	
	1973						
	10	9.18	5.6	2.54	(10)	1.95	30
	50	25.57	6.2	8.14	(10.1)	5.04	34
	1974						
	10	10.57	15.1	3.03	19.3	2.07	6.2
	50	26.96	5.4	8.63	6.0	5.33	5.8
*	1975						
	10	11.74	11.1	4.45	46.9	3.36	62.3
	50	29.13	8.0	12.76	47.9	8.72	63.6
	1976						
	10	15.38	31.0	4.59	3.1	5.11	52.1
	50	37.31	28.1	13.16	3.1	11.89	36.4
	1977						
	10	16.96	10.3	4.59	0	5.11	0
	50	41.14	10.3	13.16	0	11.89	0
	1978						
	10	16.96	0	4.59	0	7.05	38.0
	50	41.14	0	13.16	0	16.40	38.0
	1979						
	10	18.10	6.7	4.59	0	8.24	16.9
	50	43.90	6.7	13.16	0	19.01	15.9
	1980						
	10	17.41	(3.8)	4.31	(6.1)	7.78	(5.6)
	50	42.22	(3.8)	12.44	(5.5)	17.95	(5.6)

Note: It is anticipated that upgrading the Blue Shield component from the 750 fee schedule to the 14/20 fee schedule will increase Blue Shield rates by 40% which is an overall increase of 5.8% and 6.9% for single and family coverage respectively. These rates do not reflect an anticipated decrease in major medical rates due to the significant increase in the number of persons eligible for Blue Shield service benefits.

*Upgraded Blue Shield component from 500 fee schedule to 750 fee schedule by action of the State Health Benefits Commission.

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SUBCOMMITTEES:
ENVIRONMENT, ENERGY
AND NATURAL RESOURCE
MANPOWER AND HOUSING

JULY 3, 1980

DEAR FRIEND,

THE MEDICARE PROGRAM WAS DESIGNED TO HELP OLDER AMERICANS COPE WITH THE HIGH COST OF HEALTH CARE, COSTS WHICH OFTEN BECOME A BURDEN TO THOSE ON FIXED INCOMES.

OVER THE YEARS, CONGRESS HAS ENDEAVORED TO UPDATE AND REVISE THIS IMPORTANT PROGRAM AS THE NEEDS OF SENIOR CITIZENS HAVE CHANGED. RECENTLY, THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE SELECT COMMITTEE ON AGING HELD HEARINGS IN FORT LEE ON HEALTH CARE FOR THE ELDERLY.

I WOULD LIKE TO SHARE WITH YOU MY COMMENTS PRESENTED AT THE HEARING, ON THE DISCREPANCY BETWEEN MEDICARE PAYMENTS TO BERGEN COUNTY RESIDENTS, AND THE ACTUAL COST OF PHYSICIAN SERVICES.

I HOPE YOU WILL REVIEW MY STATEMENT, AND CONTINUE TO SHARE YOUR THOUGHTS ON THIS ISSUE WITH ME.

SINCERELY,

Andy Maguire

ANDREW MAGUIRE

STATEMENT BY REP. ANDREW MAGUIRE FOR THE
HEARING ON HEALTH CARE FOR THE ELDERLY

HELD BY THE SUBC. ON HEALTH & LONG-TERM CARE
JUNE 16, 1980

IN 1964, CONGRESS RESPONDED TO THE NATIONAL CONCERN OVER THE HEALTH CARE COSTS OF OLDER AMERICANS WITH THE ENACTMENT OF THE MEDICARE LEGISLATION. ADMINISTRATIVELY, THIS PROGRAM IS DIVIDED INTO 2 PARTS, A AND B. PART A PAYS FOR THE FACILITIES' (HOSPITALS, NURSING HOMES, ETC.) CHARGES FOR MEDICAL CARE AND PART B PAYS FOR THE PHYSICIANS' SERVICES. UNDER PART B, THE PHYSICIAN HAS THE OPTION OF CHARGING THE PATIENT WHO THEN SEEKS REIMBURSEMENT FROM THE MEDICARE PROGRAM, OR THE DOCTOR MAY ELECT TO CHARGE THE MEDICARE PROGRAM DIRECTLY, ACCEPTING THE PAYMENT DETERMINED BY THE PROGRAM AS THE FULL COMPENSATION FOR THE SERVI RENDERED. UNDER THIS OPTION, CALLED ASSIGNMENT, THE PHYSICIAN CAN ONLY BILL THE PATIENT FOR ANY APPLICABLE CO-INSURANCE OR DEDUCTIBLE. THE PRINCIPLE UNDERLYING THIS PROGRAM WAS A FEDERAL COMMITMENT TO ASSIST ALL OLDER AMERICANS WITH THEIR HEALTH CARE COSTS REGARDLESS OF THEIR INCOME OR PLACE OF RESIDENCE. WHILE IT DID NOT PROMISE TO UNDERWRITE THE TOTAL COST OF SENIOR CITIZE HEALTH CARE, IT DID PLEDGE TO TREAT ALL ITS BENEFICIARIES FAIRLY AND TO REIMBURSE THEM FOR THEIR COSTS IN AN EQUITABLE MANNER.

TO ACHIEVE THIS, MEDICARE ADOPTED THE CUSTOMARY, PREVAILING, AND REASONABLE COST SYSTEM (CPR) TO CALCULATE THE MAXIMUM CHARGE OF WHICH MEDICARE WOULD PAY 80%. PREVAILING COSTS WERE CALCULATED FROM PHYSICIAN POPULATIONS GROUPED BY GEOGRAPHICAL REGION. THE REGIONS, OR "LOCALITIES," WERE DRAWN SO AS TO GROUP PHYSICIAN WITH RELATIVELY DISPARATE FEES, SO THAT THE PERCENTAGE OF PHYSICIAN CHARGES COVERED BY MEDICARE WOULD BE ABOUT THE SAME FOR ALL BENEFICIARIES. SENIOR CITIZENS LIVING IN A DENSELY

POPULATED CITY WITH A HIGH COST OF LIVING AND HIGH PHYSICIANS' FEES COULD EXPECT TO HAVE ABOUT THE SAME PERCENTAGE OF THEIR COSTS REIMBURSED AS SENIORS LIVING IN A LOWER COST RURAL AREA.

TO ACHIEVE THIS SORT OF GEOGRAPHICAL EQUITY, NEW JERSEY'S MEDICARE CARRIER, THE PRUDENTIAL INSURANCE COMPANY, IN AGREEMENT WITH THE SOCIAL SECURITY ADMINISTRATION, INITIALLY DIVIDED NEW JERSEY INTO EIGHT REGIONS. ONE OF THESE REGIONS WAS EASTERN BERGEN COUNTY, A DENSELY POPULATED, HIGH-COST-OF-LIVING REGION IN THE NEW YORK METROPOLITAN AREA.

IN JULY, 1974, PRUDENTIAL, WITH THE CONCURRENCE OF THE SOCIAL SECURITY ADMINISTRATION, REDISTRICTED NEW JERSEY INTO THREE LARGE LOCALITIES, COMPRISING THE NORTHERN, MIDDLE, AND SOUTHERN THIRDS OF THE STATE. BERGEN COUNTY WAS ABSORBED INTO LOCALITY 1, WHICH ALSO INCLUDED RURAL SUSSEX, WARREN AND HUNTERDON COUNTIES, AS WELL AS OTHER URBAN AREAS IN HUDSON AND UNION COUNTIE

PRUDENTIAL JUSTIFIED THE CHANGE ON SEVERAL GROUNDS. SOME OF THE ORIGINAL AREAS, ATLANTIC CITY FOR INSTANCE, PROVED TOO SMALL TO PROVIDE A PHYSICIAN POPULATION IN SOME SPECIALTIES OF SUFFICIEN SIZE TO ESTABLISH A FAIR PREVAILING RATE. CLEARLY THIS ARGUMENT COULD NOT APPLY TO THE URBAN AREA OF NORTHEASTERN NEW JERSEY. FOR THESE AREAS, PRUDENTIAL ARGUED THAT IT WAS CONCERNED WITH THE 'SOCIOLOGICAL IMBALANCE' AMONG LOCALITIES CREATED BY RACIAL AND ECONOMIC DEMOGRAPHIC FACTORS. IT ALSO SAID THAT INCREASED POPULATION GROWTH IN THE NORTHERN AND WESTERN COUNTIES MEANT THAT THEY NO LONGER WERE "RURAL" AND SO COULD BE GROUPED WITH THE EASTERN AREAS.

WHILE IT MAY BE TRUE THAT COMBINING THE OLD REGIONS DID MAKE FOR A NEW LOCALITY WITH A MORE BALANCED RACIAL AND SOCIOECONOMIC POPULATION, I DO NOT SEE WHY SUCH A BALANCE IS DESIRABLE IN

DETERMINING A REIMBURSEMENT REGION. ONE WOULD THINK, IN FACT, THAT THE OPPOSITE WOULD BE THE CASE. MOST EVIDENCE OF WHICH I AM AWARE INDICATE THAT PHYSICIANS' FEES IN A GIVEN AREA ARE REFLECTIVE OF THE OTHER SOCIOECONOMIC INDICES OF THAT AREA. FURTHERMORE, WHILE NEW JERSEY'S RURAL AREAS HAVE BEEN GROWING FASTER THAN ITS URBAN AREAS, IT IS DOUBTFUL, TO SAY THE LEAST, THAT THIS GROWTH HAS BEEN SUFFICIENT TO ALTER THEIR ECONOMY SO THAT IT NOW RESEMBLES THAT OF THE SUBURBAN NEW YORK COUNTIES. PRUDENTIAL'S OWN CONCERN ABOUT "SOCIOLOGICAL IMBALANCE" ATTESTS TO THAT.

REDUCING THE NUMBER OF REIMBURSEMENT DISTRICTS WILL PRODUCE GREATER MANAGEMENT EFFICIENCY AND LOWER OPERATING COSTS FOR MEDICARE. THESE ARE APPRECIABLE GAINS. BUT FOR THE BENEFICIARIES IN BERGEN COUNTY, THE CONCRETE RESULT OF REDISTRICTING HAS BEEN AN INCREASE IN THE DISCREPANCY BETWEEN THE MEDICARE PAYMENTS AND THE COST OF PHYSICIAN SERVICES. THE AVERAGING IN OF RURAL AND SMALLER URBAN AREAS, WITH LOWER CUSTOMARY AND ACTUAL PHYSICIANS' FEES, BROUGHT DOWN THE PREVAILING CHARGE FROM THE LEVEL ESTABLISHED IN THE OLD BERGEN LOCALITY. SENIOR CITIZENS SUDDENLY FOUND THAT THE PERCENTAGE OF THEIR HEALTH CARE COSTS COVERED BY MEDICARE HAD FALLEN.

THE PROBLEM WAS EXACERBATED BY THE ECONOMIC INDEX IMPOSED BY SSA TO DETERMINE THE PERMISSABLE YEARLY INCREASE IN PREVAILING CHARGES. THE INDEX WAS INTRODUCED IN 1975 WITH THE WORTHY GOAL OF HOLDING DOWN THE SKYROCKETING INCREASES IN PHYSICIANS' FEES. IN PRACTICE, HOWEVER, IT HAS MEANT A DECLINE IN THE NUMBER OF DOCTORS WILLING TO TAKE PATIENTS ON ASSIGNMENT, AND A REDUCTION IN THE PERCENTAGE OF THE ACTUAL PHYSICIAN CHARGES REIMBURSED BY MEDICARE.

SINCE THE ECONOMIC INDEX IS SET FOR THE NATION AS A WHOLE, AREAS WITH INFLATION HIGHER THAN THE NATIONAL AVERAGE ARE HIT ESPECIALLY HARD. NOWHERE DOES THE ECONOMIC INDEX KEEP PACE WITH THE RATE OF INCREASE IN PHYSICIAN CHARGES, BUT IN URBAN AND SUBURBAN AREAS, MEDICARE REIMBURSEMENT LOSES GROUND EVEN MORE RAPIDLY. IN BERGEN COUNTY LESS THAN 50% OF ACTUAL COSTS TO BENEFICIARIES FOR PHYSICIANS' FEES ARE REIMBURSED BY MEDICARE.

A COMPARISON WITH NEW YORK'S REGION A, COMPRISING MANHATTAN, WILL GIVE SOME IDEA OF THE RELATIVELY LOW PREVAILING CHARGES FOR NEW JERSEY'S REGION 1. THE DIFFERENCES ARE ESPECIALLY STRIKING FOR EXPENSIVE SURGICAL PROCEDURES. IN NEW JERSEY 1, THE PREVAILING CHARGE FOR A PROSTATECTOMY IS SET AT $998. IN NEW YORK A, THE CHARGE IS SET AT $1426, OR 43% HIGHER. IN NEW JERSEY 1, A HEART CATHETERIZATION IS SET AT $427.80; IN NEW YORK A, IT IS $665, OR 55% HIGHER. NON-SURGICAL CARE SHOWS THE SAME DIFFERENTIAL. AN EXTENDED CARE FACILITY VISIT IS GIVEN A PREVAILING CHARGE OF $21.40 IN NEW JERSEY 1; IN NEW YORK A, THE FIGURE IS $28.50, OR 33% HIGHER. NOT ALL PREVAILING CHARGES IN NEW YORK A ARE SO MUCH HIGHER THAN THOSE IN NEW JERSEY 1. BUT THE TREND IS IN THIS DIRECTION.

I BELIEVE THAT MANAGERIAL SIMPLICITY AND COST CONTAINMENT ARE EXTREMELY IMPORTANT GOALS, BUT I ALSO BELIEVE THAT THEY SHOULD NOT BE PURSUED INDISCRIMINATELY TO THE DETRIMENT OF EQUITY AMONG MEDICARE BENEFICIARIES. THE CURRENT STRUCTURING OF THE REIMBURSEMENT DISTRICT IN NORTHERN NEW JERSEY DOES NOT REFLECT THE REALITIES OF PHYSICIANS' FEES AND THE COSTS OF MEDICAL CARE IN THAT REGION. I BELIEVE THAT STEPS SHOULD BE TAKEN, INCLUDING THE REDRAWING OF LOCALITY BORDERS IF NEED BE, TO RESTORE EQUITY TO MEDICARE REIMBURSEMENT POLICY.