PUBLIC HEARING

before

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

on

DRG HOSPITAL REIMBURSEMENT SYSTEM AND STATE WAIVER FOR MEDICARE

Held:
November 30, 1984
Assembly Chamber
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman
Assemblyman Richard F. Visotcky, Vice Chairman
Assemblyman Paul Cuprowski
Assemblyman Nicholas R. Felice
Assemblyman Garabed "Chuck" Haytaian

ALSO PRESENT:

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

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ASSEMBLYMAN GEORGE J. OTLOWSKI (Chairman): Please come to order. First of all, I owe all of you an apology, and I want to make that apology right from the very outset. I am sorry about the delay. I think the people who are responsible for the amplification here owe me an apology, because we are not ready with the amplification. We are going to go ahead anyway.

I want to point out some of the things I am going to ask everyone to observe. When the Committee decided to hold these hearings, the decision was not made because we had a fixed opinion, or a fixed position. We decided the hearings were necessary so that we could review this whole question openly and fairly, hearing all sides. After we hold these hearings, we will then make a determination about whether the system is satisfactory, whether there is legislation needed, and whether there are any amendments needed. These are things that could result from the hearings.

Again, I want to emphasize that this Committee -- and it is unanimous -- has no fixed position. I think this Committee, over the years, has had the reputation of being fair, and of conducting its hearings openly, frankly, and expeditiously. As a matter of fact, in many cases after the hearings are concluded, we may have done nothing because nothing was warranted to be done. On the other hand, hearings have been held and legislation has resulted, amendments have resulted, or we made a report to the Administration calling its attention to some of the things we heard at the hearings which we thought were administrative problems, not legislative problems.

I just want to set that for background because I am getting the feeling that everyone out there wants to run this hearing this morning and, of course, that is not going to happen. We are going to conduct the hearing the way we usually do. This is the first of a series of hearings on this subject. To people who are inconvenienced today, or who may be inconvenienced, I apologize again. We will probably have at least two or three more hearings on this subject. Those dates, of course, will be set later.

Now, what we are going to do this morning is, we will call first upon any Assemblyman who is here. Then we will call on any

Senator who wishes to testify, followed by the Commissioner of Health, and then any other Commissioner who may be present. After that, I am going to make a determination about who is going to be heard, and then the Committee will go right on through lunch. We will conclude this hearing at 2:00 p.m. I want everyone to know that. As I indicated, the next hearing will be announced.

In the meantime, for those people who feel they would like to submit written testimony, those who do not want to come back to the subsequent hearings, please submit your written testimony to David Price so the Committee and the staff will have the benefit of your reports.

So much for that. At this point, I am going to call the Committee to order and ask our Aide to call the roll.

MR. PRICE: Assemblyman Otlowski?

ASSEMBLYMAN OTLOWSKI: Present.

MR. PRICE: Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Here.

MR. PRICE: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Here.

MR. PRICE: Assemblyman Felice?

ASSEMBLYMAN FELICE: Here.

MR. PRICE: Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: Here.

ASSEMBLYMAN OTLOWSKI: I understand that before the hearing gets underway, a Committee member, namely Assemblyman Felice, would like to make a statement. Assemblyman Felice, may we hear from you, please?

ASSEMBLYMAN FELICE: Yes, if I may. Mr. Chairman, members of the Committee, ladies and gentlemen: About five months ago, I was privileged to represent the State at a meeting in New Orleans with 29 other states on the DRG program and the different effects it will have. The State of New Jersey is one of the leaders in the country; in fact, the Federal government followed our program. We received a tremendous amount of information, which will be distributed for all of us to analyze so we can look at the different reasons why many of the

states in the country are following the lead of the Northeast, especially New Jersey.

The Chairman and the Committee will be putting up a resolution next week on an emergency basis. It is my resolution, AR-62, which is memorializing Congress to extend the Medicare waiver date to 1986. This means, of course, hundreds of millions of dollars for the State. Thanks to the Chairman and the Committee members, we hope next week to put this up as an emergency so that New Jersey will be protected, in the hope that the Federal government will extend our waiver.

Mr. Chairman, thank you very much.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Assemblyman Felice. We are now ready to proceed, and I am going to call on Assemblyman C. William Haines first. Assemblyman, for the record, will you identify yourself, please?

ASSEMBLYMAN C. WILLIAM HAINES: My name is William Haines. I am an Assemblyman representing the Eighth District, which encompasses the larger share of Burlington County. I am sitting here representing this district and, also, I am a member of the Board of Trustees of the Burlington County Memorial Hospital.

My experience in health care goes back a few years. I was State Director of Farmers Home Administration for three states, New Jersey, Delaware, and Maryland, from 1971 to 1976. During that period of time, we made the first hospital loan in the nation to Salem Hospital. Subsequent to that, we made many hospital loans in New Jersey. I think the largest loan was made to Hunterdon Medical Center for $16 million. That was the largest hospital loan made to that date. We averaged about $20 million worth of hospital loans a year. So, I have some experience in the health care field.

One of the things that bothered me during those days was that we spent an inordinate amount of time processing applications for hospital construction. In fact, it seemed to me that the time spent before various State agencies probably added to the cost, to the tune of as much as 25% of the cost. This bothered me a great deal and was one of the reasons, subsequent to that, upon leaving the Federal government, I decided to run for the State Legislature.

In Burlington County, and in many of the South Jersey counties, in the past we have been very careful about keeping our health care costs down. At Memorial Hospital, in the past, we have cared for as much as 70% of the indigent in Burlington County. We have also been able to keep our costs down in the hospital. Over the last few years, we have gotten involved in the DRG program and, in my opinion, the DRG program has increased health care costs to the residents of Burlington County. The increase in costs has been because of the fact that we have had to hire a great number of administrative personnel to comply with the regulations. At the present time, we are in the process of looking forward to the possibility of laying people off in the hospital because of the fact that the dollars are just not coming in under the DRG program. We have a more expensive program, and yet our hospital is not doing nearly as well. In fact, the current statistics I have show that if we continue with a waiver, Burlington County will stand to lose, over the next three years, $15 million. Ocean County -- if we go ahead with the waiver -- will lose $20 million.

I would like to ask some questions related to the Medicare waiver which I would like to have in the record:

(1) Why should New Jersey be willing and anxious to give up $126 million in Medicare money? Isn't it true that New Jersey is now among the four lowest of all the 50 states in terms of state moneys sent to Washington, as compared to Federal moneys returned to New Jersey?

(2) Does the Department of Health have a contingency plan if the Federal Health Care Financing Administration turns down the waiver?

(a) If the answer is yes, an oral description of the plan should be requested, and a written description of the plan should be provided within a specified number of days.

(b) If the answer is no, it's open season on the Department.

(3) Is it not true that under the State's DRG system, Medicare is shouldering an unfair portion of the State's indigent costs?

(4) Why is the Medicare PPS System paying so much more per DRG than New Jersey?

(5) Has the Department investigated alternative systems for financing uncompensated care? Can you tell us what other states are doing, for example, Florida and New York?

(6) Is the Department prepared to make further reductions in reimbursement to hospitals in 1985 if HCFA makes such reductions a condition of extending the waiver?

(7) If the answer to Number 6 is yes, what is the maximum acceptable reduction consistent with quality health care?

(8) Is it correct that the Department has promulgated reimbursement regulations effective 1985 that will further reduce reimbursement to hospitals by an additional $60 million?

These are questions I think need to be answered. I know this is a very, very complicated subject; it has been for me, a resident of South Jersey, and a resident in an area where people are very conscientious, an area where people have traditionally tried to, I would say -- I have a Quaker background -- keep costs down. We have done a good job of keeping costs down. Now, we come under regulations and we find that we are running short of money to operate the hospital properly. Where do we go from here? This is the question I think you folks are trying to answer. I am also interested in trying to find the answer.

Thank you very much for asking me to appear.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Assemblyman Haines. Would you just hold it a minute, Assemblyman Visotcky has a question.

ASSEMBLYMAN VISOTCKY: You mentioned some hospitals. Did those hospitals ever appeal to the Department of Health on the cost factor?

ASSEMBLYMAN HAINES: Yes.

ASSEMBLYMAN VISOTCKY: Have they been rejected?

ASSEMBLYMAN HAINES: Yes, they have. You know, it's a process; it's a tough process.

ASSEMBLYMAN VISOTCKY: The question was, have they been rejected?

ASSEMBLYMAN HAINES: Yes, they have been rejected. They have gone back again for other appeals. This thing has been a very, very tough procedure.

ASSEMBLYMAN VISOTCKY: I appreciate your speaking, but I think this Committee is looking at the entire State of New Jersey, not just Ocean County or Burlington County.

ASSEMBLYMAN HAINES: Assemblyman Visotcky, I agree with what you're saying, and I'm sure that things are different in other parts of the State. Oftentimes, we in South Jersey feel that when North Jersey gets a cold, we end up getting pneumonia. This happens--

ASSEMBLYMAN VISOTCKY: (interrupting) We help to treat you, though. (laughter)

ASSEMBLYMAN OTLOWSKI: Are there any other questions? (negative response) Assemblyman Haines, thank you very, very much.

ASSEMBLYMAN HAINES: I would just like to quote Will Rogers, who said, "It is just a wonderful thing that we don't get as much government as we pay for."

ASSEMBLYMAN HAYTAIAN: Before the Assemblyman goes, could we have a copy of those questions?

ASSEMBLYMAN OTLOWSKI: Do you have a copy of those?

ASSEMBLYMAN HAINES: Yes.

ASSEMBLYMAN OTLOWSKI: David, will you please make copies of this for every member of the Committee? (affirmative response)

I understand Assemblyman John Doyle wanted to be heard. Is Assemblyman Doyle here? (negative response) If not, we are going to go to Commissioner Goldstein. Commissioner, it is a great delight to see you. As a matter of fact, it was even suggested that we applaud the fact that you are here today. It is good to see you.

COMMISSIONER J. RICHARD GOLDSTEIN: Thank you very much. I would have been here for the other session -- you mentioned that I wasn't here -- but I was testifying on the mandatory seat belt legislation.

I would like to introduce Christine Grant from my staff, who will handle any of the technical questions, depending on that level of interest you want to get into. The Department is prepared--

ASSEMBLYMAN OTLOWSKI: (interrupting) Do you have a fixed statement to make, a preliminary statement?

COMMISSIONER GOLDSTEIN: Yes, I do.

ASSEMBLYMAN OTLOWSKI: Wonderful.

COMMISSIONER GOLDSTEIN: Thank you for the opportunity to be with you this morning to speak on this very important issue facing our State. I would like to stress at the outset that I believe the New Jersey system has been, and can continue to be, very effective in controlling health care costs and assuring quality medical care.

The DRG system was implemented in New Jersey's 90 acute care hospitals over a three-year phase-in period. Twenty-six hospitals entered the system in 1980; 35 additional hospitals entered in 1981; and, the remaining 29 entered in 1982. This gradual phasing in was deliberately planned so that the problems with implementing such an innovative and different payment system could be more easily resolved.

The results for the first three years of operation, 1980 through 1982, are complete and the hospitals are now submitting their 1983 financial and statistical data to the Department of Health. While the initial results are favorable, we believe that the real cost containment effects of the system will be more pronounced for 1985 and subsequent years. As hospitals and physicians gain more experience working with the system, we believe we will see more efficient and effective delivery of health care services. The effects of the DRG system can be illustrated by comparing the statistics from those hospitals which entered the system during 1980 and 1981 with the national averages.

In one year, 1980, the DRG hospitals' total operating expenses increased at a rate of 13.8%, while the national increase was 17%. During the second year, the 61 hospitals now in the system experienced an increase in total operating expenses of 14%, while the national increase was 18.7%.

One of the most important characteristics of the DRG system is full payment for the treatment of the medically indigent. This feature provided needed revenue to our inner-city hospitals which previously experienced substantial operating losses. Additionally, payments were made in the years of entry into the system to account for working capital needs of those hospitals that had cash shortages due to

services rendered to the medically indigent. Hospital revenue statistics show a sharp increase in the first year on the system and then drop to the anticipated levels. For example, in 1980, the DRG hospitals had an increase in total revenues of 20.2%, while in the second year their revenues rose only 13.2%.

The first group of DRG hospitals showed a 1.6% decrease in length of stay in 1980, a 2.6% decrease in length of stay in 1981, and a 3% decrease in length of stay for 1982. Nationally, for that time period, length of stay remained essentially constant.

The issue of patient length of stay naturally leads to the question of the quality of care which patients are receiving under the DRG program.

The New Jersey Department of Health has focused major attention on this issue since the inception of the DRG system. In 1980, the Department insisted that a utilization review be performed for all patients. Working with professional standards review organizations, the Department was able to implement the utilization review system in March, 1981. By 1982, the Department required all review organizations to establish monitoring systems designed to study changes in admission and discharge patterns. To date, the utilization review organizations have not presented any evidence of premature discharge to the Department. Another major feature of the New Jersey system is the Commissioner's Physician Advisory Committee, which provides consultation directly to me regarding the issues of quality and clinical practice under the DRG system. This group of physicians has developed clinical criteria to monitor quality thresholds on an aggregate level. The Committee and the Department are carefully reviewing the issue of readmissions. We have identified the types of cases which should be studied to determine the effect of the DRG system on early discharge and readmission.

In 1983, two professional standards review organizations undertook a study to determine the effect of the DRG system on early discharge and readmission. The results of this study, which was completed this past July, indicate that the DRG system in New Jersey has not caused a decrease in the quality of hospital care, as evidenced

by the fact that no increase has occurred in the rate of early discharges, deaths, or readmissions. In fact, the increased concern and focus on quality care brought about by the implementation of the DRG system has served to strengthen the awareness of health care practices.

I am personally committed to working with any responsible group to study this issue. I believe the DRG system can be cost effective while ensuring quality medical care. The Department will continue its efforts on utilization review and will encourage hospitals and physicians to do effective discharge planning.

I would also like to touch on the several important differences which exist between the New Jersey DRG system and the national DRG system which took effect in October, 1983. These differences make it imperative that New Jersey's waiver be extended so that we may continue to operate our current and successful system.

First, in New Jersey under the waiver, we have an all payer system, so there is no potential for cost shifting since everyone pays the same amount. By contrast, the national system covers only Medicare, and there is the danger that costs will be shifted to Blue Cross and commercial insurers.

Second, the New Jersey system incorporates payments for the uncompensated care of the indigent, working capital needs, and the maintenance and replacement of the physical plant and equipment. These additional financial elements are not included in the national Medicare system. It is estimated that uncompensated care in New Jersey will cost approximately $225 million during 1985. Under the New Jersey system, Medicare shares in approximately $90 million of this burden. However, under the national system, Medicare does not contribute to any of this cost.

Third, in New Jersey there is an avenue of appeal to the Hospital Rate Setting Commission, while the national system does not provide redress opportunities for either hospital reimbursement adjustment or State-level review.

Fourth, the New Jersey system recognizes the unique differences which may exist between New Jersey hospitals, while the

national system will move to a flat price per case for the whole country.

Fifth, through its health planning and Certificate of Need process, the Department has the ability to control the development of new services and capital expansion in concert with its rate setting system.

Sixth, New Jersey's current system and its inclusion of uncompensated care has increased access to care for the most vulnerable segment of our society, the medically indigent. While the national system will result in a restricted access to care for the indigent and the elderly, this is not, nor will it be, the case in New Jersey.

Last, and highly important to the operation of a successful program, is the fact that the DRG system in New Jersey is administered at the State level. The health care industry in New Jersey had a great deal of input into the design and implementation of the system. We have a vigorous and responsive health care network in the State that is dedicated to the early identification of problems and the assembling of pertinent information to arrive at fair and equitable solutions. Open and meaningful communication between the regulating agency and all facets of the industry most assuredly encourages cooperation and leads to a better system.

In summary, I believe that the DRG system is a cost effective system and that we have found no evidence of a decline in the quality of medical care. As a physician, and as the State Commissioner of Health, I am firmly convinced that the New Jersey system has numerous advantages over the national system, and that it is critically important to extend our Medicare waiver.

Thank you, and I will be happy to answer any questions the Committee may have.

ASSEMBLYMAN OTLOWSKI: Thank you. Commissioner, just to be helpful to the Committee, would you just briefly -- you know, in your own words without referring to the text -- tell us the difference between the State system and the Federal system? Could you just point out the differences? You pointed them out in your formal statement, but I think we ought to develop that just a little more thoroughly.

COMMISSIONER GOLDSTEIN: There are two critical areas of differences, as well as the number of differences I mentioned. One is that we are an all payer system, and the second is that our system includes payment for uncompensated care. Now, let me explain the two.

Under an all payer system, everyone who is charged for a hospital bill for the same problem will get the same bill in the same hospital. That is the basis of an all payer system.

ASSEMBLYMAN OTLOWSKI: In New Jersey?

COMMISSIONER GOLDSTEIN: In New Jersey. Now, in other states which do not have an all payer system, the rates are not the same for all parties. What tends to happen is that when one party, like Medicare, which pays upwards of 40% to 50% of the total hospital bills-- If their payments are not adequate to the hospitals, the hospitals make up the difference in revenue by passing the costs on to all of the other insurance parties, so Blue Cross rates go up, the private insurance rates go up, etc. So, while Medicare will save money under their system by fixing their rates, the system will not save money. The entire health care system does not save money. It is called cost shifting. Now, there are limits to how much cost shifting the private insurance carriers can absorb. This is where poor people get hurt. In many states, cost shifting is how they have managed to take care of poor people, and by having Blue Cross and others pick up that insurance policy. But, with Medicare continuing to lower rates, it becomes more and more difficult for the insurance industry to manage to pick up those costs, and poor people are the ones who get hurt. There have been headlines in other states where they have the national DRG program. The hospitals cannot manage the uncompensated care patients, and are sending them to the indigent care hospitals in droves, thus creating great financial burdens on the communities and states which have that problem.

ASSEMBLYMAN OTLOWSKI: Commissioner, there is one thing I think we ought to have everyone understand and, certainly, we want you to understand it. The Committee discussed this for a moment before we came out here. It is not the purpose of this Committee to hinder the Administration, or you, for that matter, from pursuing the appeal you

now have in position with the Federal government. As a matter of fact, this hearing was scheduled long before you got into that.

What I want to point out is, that is the Administration's business. We are not going to do anything to embarrass the Administration or to compromise the Administration. As a matter of fact, we even feel we have an obligation to be helpful. But, that isn't the purpose of the hearing, as you well know, and as I indicated from the outset.

I think one of the things the Committee wants to know is, suppose all things fail? What kind of impact do you anticipate on the State of New Jersey, for example, on the third-party payers, on the counties, which may have to pick up the tab, and on the other people who will be affected? That is one of the things the Committee is going to do later on. Before we adjourn today, I am going to ask our staff people to get a hold of the legislative fiscal people to explore that and to give us figures on it. Would you please comment on some of the things I raised just now?

COMMISSIONER GOLDSTEIN: Well, first, let me state that there is no specific plan in mind as to what the State will do if our waiver is denied. Secondly, at the same time, it would obviously be irresponsible if the Department of Health did not do contingency planning and think about the types of issues you have raised. We have a group of people who do this type of contingency analysis. I also wish to make it very clear that the thrust of the efforts in the Health Department are geared to securing the waiver, not to developing some kind of a plan which we would unfold to the world if the waiver were denied. That is not the case.

ASSEMBLYMAN OTLOWSKI: That is your business, and we would think less of you if you did not pursue it vigorously. That is your business; our business is to conduct this hearing.

COMMISSIONER GOLDSTEIN: Right. Obviously, I cannot get into any specifics about what the solution would be, but I can point out to you, in response to your question, what some of the problems are which we have to solve.

As I stated earlier, the Medicare portion of the uncompensated care is $90 million. If Medicare were not participating, but reflecting what their payments would be, when we take a look at the difference between what they would be paying in New Jersey and their lack of contribution to that $90 million, we end up with a $50 million difference. All right? That basically defines the extent of the dollar problem to the State of New Jersey. Our system, one way or the other, would be short $50 million. How would we respond to make up that $50 million? What kind of a system would we put into effect which would deal with that shortfall of cash that basically would be addressed by whatever plan the Health Department could come forward with?

ASSEMBLYMAN OTLOWSKI: Commissioner, the other thing is, I want to give you this opportunity in fairness, because I think what the Assemblyman was talking about was the hospital in his particular district that is hurt by this system which is in operation in New Jersey, and I suppose there are other hospitals which may have a similar complaint. Do you have any comment to make on that?

COMMISSIONER GOLDSTEIN: Yes. As implied, the hospitals are not losing money. All right? The hospitals will not make as much money as they otherwise would make if they had the national system here in New Jersey. Now, when I say that, let's put some caveats to it. The national system stands today as it exists in 1984. We have done projections based on what it is today, assuming no changes in the national system, that is, that they go ahead and do it exactly the way they have said they are going to do it until 1987. We have calculated all of that out. Medicare has been absolutely clear; they have been sending signals in a very straightforward fashion that they are going to reduce expenditures. So, the amount of money these hospitals would not be bringing in, based on today's projections, in our view, is vastly overstated because we feel Medicare will clamp down. But, we are not talking about taking money away from them; we are talking about future years not earning as much as they otherwise would have earned under the Medicare system.

ASSEMBLYMAN OTLOWSKI: Commissioner, following that line of questioning, if a hospital under the present system alleges it is hurting, it is entitled to a hearing to prove its case. Am I correct about that?

COMMISSIONER GOLDSTEIN: Absolutely.

ASSEMBLYMAN OTLOWSKI: And, if it can prove its case, you have to act to meet that. Am I correct about that?

COMMISSIONER GOLDSTEIN: Yes.

ASSEMBLYMAN OTLOWSKI: So, the system is flexible enough to meet that, and the door is open for constant reviews?

COMMISSIONER GOLDSTEIN: Yes.

ASSEMBLYMAN OTLOWSKI: Assemblyman Visotcky, do you have any questions?

ASSEMBLYMAN VISOTCKY: Yes. Commissioner, did you receive a formal communication as to the approval of the waiver? If so, will you please provide the Committee with a copy of that communication?

COMMISSIONER GOLDSTEIN: We have received no communication. I'm sorry; please be more specific. We have not received approval of the waiver.

ASSEMBLYMAN VISOTCKY: I'm referring to the 21-page document you received in your Department.

COMMISSIONER GOLDSTEIN: We received an analysis from the HCFA staff two and a half to three weeks ago. But, I would also point out to the Committee that time marches on. We have had informal negotiations going on with HCFA's staff both verbally and in writing. The situation is very much different today than it was when that letter was composed. So, I am not certain what purpose it would serve, except to look at the historical documentation of what their concerns were at that point in time.

ASSEMBLYMAN VISOTCKY: In the interest of staff, I am just sort of curious to see what kinds of questions they raised so we can help them as far as the legislation goes, if need be.

COMMISSIONER GOLDSTEIN: We will provide the Committee with copies of that.

ASSEMBLYMAN VISOTCKY: I will appreciate it very much. When do we expect final waiver approval?

COMMISSIONER GOLDSTEIN: Before December 31.

ASSEMBLYMAN VISOTCKY: We realize it will be before December 31.

COMMISSIONER GOLDSTEIN: If we do not receive approval, that is to say if we should receive a denial, our system will terminate on December 31 and we will be on PPS January 1. Let me also state very quickly, since I am being recorded, that we have no expectations of losing the waiver.

ASSEMBLYMAN VISOTCKY: Aren't we coming to the eleventh hour without a system being in place in case we should lose these moneys? Aren't we waiting until the last minute to do something, which may cause chaos?

COMMISSIONER GOLDSTEIN: Number one, the system would change for Medicare only initially. Number two, in terms of the eleventh hour, it was not the Department of Health's idea to have this done at the eleventh hour. One would have to follow the entire historical pattern, but it was not at our doing that these deadlines were set. It was at Medicare's doing that the deadlines were set for when our waiver would terminate, for when our application was due, for the review cycle, etc. I am not particularly comfortable with the eleventh hour situation. It makes me quite anxious; I know it makes the health care community anxious; and, I know it makes the Legislature anxious. That is simply the way events have unfolded. However, it is my opinion that the negotiations with Medicare are going quite smoothly at this point, and I am extremely optimistic that we will secure our waiver.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Thank you very much, Mr. Chairman. Commissioner, could you answer this question relative to staffing? Does the Department of Health have adequate staff to thoroughly review the records submitted by hospitals to justify their rate requests? If so, then why has it taken a year to 18 months in some cases, if that is the correct information?

COMMISSIONER GOLDSTEIN: Does the Department have sufficient staff within the health planning area? My response is, I think the staffing is sufficient. I know that some of my staff members might not

agree with me. My staff would also argue that they are really not that far behind in reviewing-- Are you talking about reconciliations?

ASSEMBLYMAN CUPROWSKI: Yes, reconciliations.

COMMISSIONER GOLDSTEIN: I think it should be made clear that the problem of reconciliation is not totally a problem within the Department of Health. Let's make a very simple analogy. It is just like a taxpayer having a problem with the IRS. When the IRS asks for information, the individual has to go back and get it. The hospitals have to put their information together in such a way that it can be reconciled. So, the problem isn't necessarily that the Health Department isn't reviewing the information rapidly enough. In most instances, it is that we have asked for additional information and the hospital has to go back and get it.

ASSEMBLYMAN CUPROWSKI: Is a year, or in some cases 18 months, a fair amount of time for a reconciliation?

COMMISSIONER GOLDSTEIN: Let me have Christine Grant answer that, rather than have her tell me and then me tell you.

CHRISTINE M. GRANT: My name is Christine Grant; I am the Director of Hospital Reimbursement. The Hospital Reimbursement Program is engaged in several kinds of reviews. There is the annual review of the hospital's appeal. It would be most unusual for a hospital's appeal for items it feels are not adequately covered in its rates to be 18 months behind. That would be most unusual. Essentially, reconciliation is a post-year closing of the books, so there is a determination whether during the year an adequate and accurate amount of cash flowed to the hospital. In some cases, more than was adequate flowed; in some cases, less.

At the present time, it would be accurate to say that there are a good number of hospitals for which 1983 reconciliations, for example, are not complete. As the Commissioner indicated, there are reasons for that. A hospital would not have submitted its 1983 final documents until the end of May at the earliest under our regulations. I would say this is an area the Department is aware of and is working on, because we, as well as the hospitals, would like to improve that.

ASSEMBLYMAN CUPROWSKI: Has it improved though?

MS. GRANT: Has it improved? It has not gotten worse as far as the time lag is concerned. The issue is that the last wave of hospitals, the third wave of hospitals to come on the system initially, was in 1982. Therefore, their first full year of experience for all 90 hospitals was, in fact, 1983. So, in effect, all 90 hospitals were on the system for the first time in 1983. Therefore, I think it is premature at this point to judge 1983 as where we will be next year.

ASSEMBLYMAN CUPROWSKI: Are there hospitals in the State of New Jersey that still have outstanding reconciliations from 1981 and 1982?

MS. GRANT: I am not aware of any, but I would stand corrected if there is an isolated instance. It is my understanding that 1982 is now closed.

ASSEMBLYMAN CUPROWSKI: I have one more question. The Department of Health, talking about the all payer DRG system, will save the Medicare system $126 million, I believe, over 1985-1987. Certain members of the New Jersey Hospital Association consider that a loss to the hospitals. Would you like to comment on that?

COMMISSIONER GOLDSTEIN: Assemblyman Cuprowski, to answer your question about the $126 million, this is a projection of what PPS would pay in New Jersey if we did not have the waiver. In other words, our argument is, it will cost Medicare more money if they do not give us the waiver. Now, the hospitals that would earn some of that $126 million simply look at it and say, "Well, if we had PPS, we would be better off. More cash would be coming into our hospitals." There is a several part answer to that.

Number one is, New Jersey hospitals are more efficient. We are not talking about reducing the quality of care in those hospitals. They are simply looking at the possibility of having a windfall come to them if they change systems. Number two, the money is not -- like tax revenue -- coming back into New Jersey. We're talking about the Medicare Trust Fund, which can go broke. So, to what extent we can save the Medicare Trust Fund, all of our elderly benefit. Number three, and this is the most critical, the real subject here is, what will Medicare do? Will they really keep to the rates and to the system

they have outlined over the three-year period, or will they end up freezing the rates next year and not increase them the way they have indicated they will, etc.? In other words, the $126 million is a future projection. Medicare has already expressed very clearly -- on a national basis -- that they have to tighten up. They are going to have to find ways to tighten up; they cannot deal with increases in their budget. They are at least going to have to take it down and cap it in some fashion.

So, we do not feel that the $126 million those hospitals are talking about is real. We think Medicare is going to take action, and that those savings may totally disappear. It is very difficult at this point in time. We are simply looking at the system today and saying, "Well Medicare, if you stick to your game plan for the three-year period, you will save $126 million in New Jersey." However, we expect them to change their game plan.

ASSEMBLYMAN CUPROWSKI: I have one final question, Mr. Chairman, if I may. Assemblyman Haines indicated that Burlington County will conceivably lose $15 million or so under the DRG system if the waiver--

COMMISSIONER GOLDSTEIN: (interrupting) Let me ask our analyst to answer that question.

ASSEMBLYMAN CUPROWSKI: Hudson County -- the County I represent -- will be hurt if we do not have the waiver, by approximately $14 million.

COMMISSIONER GOLDSTEIN: Let's be clear. We have hospitals which have a high percentage of poor patients -- high uncompensated care -- that clearly love our system. The hospital that has a high elderly population with no poor people using it, will not like our system when comparing it to the national system. However, if the national system really ratchets down and pays them less, they will suddenly be back here saying, "Wait a minute, we would prefer the New Jersey system." But, there is a difference in the patient population of these individual hospitals. Now, as to whether there are any specifics for these hospitals, let me ask Christine Grant to comment.

MS. GRANT: Did you have a specific question?

ASSEMBLYMAN CUPROWSKI: No, I think the point I wanted to address was the difference of population, as you described, and case population, if you will, where indigent care is-- For example, in Jersey City and in some other cities, those hospitals, in effect, will suffer if we do not get the waiver, and those which don't necessarily have that type of population may benefit or lose. So, I think it all depends on exactly what geographical location in New Jersey we are talking about.

COMMISSIONER GOLDSTEIN: All right. But, the overall problem is that the State, on a statewide basis, would be short $50 million without the waiver. You are correct in pointing this out. It is an old distribution problem. Some hospitals would be high, but others would be hurting.

ASSEMBLYMAN CUPROWSKI: Thank you very much.

ASSEMBLYMAN FELICE: Mr. Chairman, if I may.

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice?

ASSEMBLYMAN FELICE: I think the key to that, and it was brought out with the 29 states participating, is the efficiency of a hospital. In Bergen County, there is a hospital that is quite well set in a suburban area. It's Valley Hospital. Valley Hospital is cited in the United States as a hospital that is very low as far as indigent patients are concerned. Yet, they were able to not only get out of the red, but actually to start to go into the black. Again, a lot of the analyses about individual hospitals in individual areas basically, like any other business, depend on the efficiency of how a hospital is run. Certainly, they have decreased their length of stay, have had pre-admission testing before operations, and the whole program. I think a lot of the questions of where, how, and how much depend on the efficiency of a hospital in an area. I think that has to be accredited to the administration also.

COMMISSIONER GOLDSTEIN: Right. Let's be absolutely clear. We are not talking about hospitals losing money. We are talking about hospitals not making as much money. I think it is interesting to look at why that occurs. If the national system is supposed to be so cost saving, why, if New Jersey went on that system, would some of our

hospitals make more money? In fact, it is because we are already more efficient than the national hospitals. So, the diet the Feds are going to put all of the other hospitals on is going to slim them down, but when they put New Jersey hospitals on that diet, our hospitals could actually gain weight because we are already providing the services more efficiently. We are saving the Medicare Trust Fund money. That has to be a priority too. What would be the rationale of pouring money into a hospital when it is doing a very good job now of taking care of its patients? Where is the rationale to do that?

ASSEMBLYMAN OTLOWSKI: Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: Thank you, Mr. Chairman. I really don't know if I need this, but, Commissioner, you talked about the $50 million. What will happen if all fails and we do not get the waiver, and we go onto the national system and there is a difference of $50 million? Where is that going to be made up and how?

COMMISSIONER GOLDSTEIN: I don't have a specific answer. I was outlining the extent of the problem, not the solution. We have a group in our Department which is looking at the options. We are doing contingency planning, but we have not gone forward, we have not publicized it, and we have not presented it to the Governor. He has no contingency plan he knows of yet because he has not asked us for one. We obviously, like good Boy Scouts, believe in being prepared. Should the Governor turn to us and say, "Okay, what are my options?" we will have his options analyzed. But, in terms of going ahead with any of those options, we would obviously, very quickly, have to get into a dialogue with the Legislature and with the hospital community to pick the option that New Jerseyans would most favor.

ASSEMBLYMAN HAYTAIAN: Thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice, when you asked your question, did that satisfy you as far as any questions you may have had?

ASSEMBLYMAN FELICE: Yes.

ASSEMBLYMAN OTLOWSKI: Commissioner, we are going to make sure that we are in close liaison with you during this period, so we can be kept abreast of what is happening in the event we have to do

something special or something specific. I just want you to know we are that close to you. We will be watching this very closely so that, if need be, we will be able to act.

Commissioner, is there anything you would like to add, in view of all of the questions and in view of your prepared statement? Is there anything which developed during the course of our questioning you feel you would like to expand on?

COMMISSIONER GOLDSTEIN: I would only say this, Mr. Chairman: The DRG system is a program that was developed fundamentally by New Jerseyans. We did have some outside help in developing it; I am not trying to say that you had to be born and raised in New Jersey to know anything about DRGs. But, we were the State that had the guts to go ahead with this program. We developed it. Our hospital system, the administrators, the physicians, our State officials, the Legislature, and everyone involved, worked very hard to create this system, which the Federal government is emulating in some very special ways.

Over the course of this time, because of the amount of data and some of the difficulty in reconciling the data on a timely basis, we received a lot of lumps in the press and elsewhere which stung, but we were not in a position at that time to refute them. We now have the data. We think our waiver is going to be granted. Medicare is the most difficult judge of how our system is performing. We are certainly hopeful that when we gain this waiver it will be recognized throughout the United States as the success New Jerseyans had in putting together this program. We think a great deal of pride should be expressed in terms of developing this program. Because it is such a good news program, it is really a story which has not been told. We have been criticized for not saving money; we saved money. We have been criticized that the system lowered the quality of care; we have been able, after a lengthy study, to demonstrate absolutely no impact on the quality of care. In fact, the argument is that the quality of care is increasing, because hospitals certainly have no rational reason to want to see any complications of patients occurring in their hospitals. The less complications, the faster the patients heal, is now the way the incentive system works, and it is the way it should work.

Lastly, we do not have poor people knocking at the doors of our hospitals. We do not have headlines stating that there is no way to take care of these people. In New Jersey, it is a good-news story that doesn't get told because good news normally is not told. But, the bad news, or the alleged bad news of our system has been told. It has been spread. The New York Times has had editorials on the fact that our system is not cost effective. We really looked forward to this opportunity. We were delighted to be invited here today to testify in support of our system. I think you are going to be very surprised at the tremendous amount of support our system has from the insurance industry, from the hospital industry, and throughout the State. I think you are going to be really surprised about how successful this program is.

I want to thank you for inviting me here today to testify.

ASSEMBLYMAN OTLOWSKI: Thank you, Commissioner. Assemblyman Visotcky has a question.

ASSEMBLYMAN VISOTCKY: Commissioner, how do you get from $225 million uncompensated care to $50 million uncompensated care? Could you explain that to me?

COMMISSIONER GOLDSTEIN: Yes, it is very simple. It is a question of an entire pie and a piece of a pie. The entire uncompensated care bill was estimated at $225 million. Medicare is participating in paying a piece of that. Their piece of that $225 million is about $90 million. So, Medicare does not participate in our waiver system. We are only out $90 million without changing the rates to any of the other insurance companies. So, we only have a $90 million problem to start with. When we go on PPS, our studies show that in the first year we will actually cost Medicare money. We will cost them $40 million. But, while we are costing them $40 million, we also include in that the fact that they are paying $90 million. However, they won't be paying that $90 million. So, you take the $40 million from the $90 million and you end up where we are short $50 million.

ASSEMBLYMAN VISOTCKY: Now you have me screwed up more than you did before. (laughter) I have another question. What do you

think of HCFA's attitude toward the concept of an all payer system, specifically the inclusion of the indigent care costs here in New Jersey?

COMMISSIONER GOLDSTEIN: Are you asking me what Medicare thinks of that, or HCFA?

ASSEMBLYMAN VISOTCKY: HCFA.

COMMISSIONER GOLDSTEIN: Well, I can't respond for HCFA. I can respond that there are parties in this country which are opposed to all payer systems. Primarily it is members of the private, for-profit hospital industry which are opposed to all payer systems, and the reason is very simple. They cannot cost shift within their hospitals and not adversely affect their profits.

But, Medicare is dealing with a statute. I don't know that their particular opinions are necessarily relevant to how they will act on the approval of our waiver. We had a demonstration contract with Medicare, which is an all payer system. We are asking for a continuation of that system which is an all payer system, and the statute says that if we save Medicare money -- if our system costs a dollar less than their system otherwise would have -- we are entitled to be granted our waiver. It says nothing in the statute about how anyone feels about all payer systems, or uncompensated care. I also point out that uncompensated care is not an element of cost that Medicare pays anywhere else except in the four waivered states. So, one can imagine that as a bureaucracy they would like to have all of their systems operate exactly the same, but, again, the statutes are what are involved here, not any personal feelings the bureaucracy may have.

ASSEMBLYMAN VISOTCKY: Can we assume that if we do not get the waiver -- I hope we do get it -- that third-party systems will be increased?

MS. GRANT: Absolutely.

COMMISSIONER GOLDSTEIN: Well, it's a question of making up that $50 million. Perhaps other people will want to explore the options with you as they see them. I don't think it would be helpful for me to do that. Clearly the choices are, you either pick up that

$50 million or a piece of the $50 million, or you do not. Then it is simply a question of who is going to pay the $50 million, whether it comes out of State revenue, whether it comes out of cost shifting to the privates, or whether it comes out of county taxes. I mean, obviously there are a lot of different ways to make up the $50 million. Of any plans, we would like to see the one that is least disruptive to the existing system. We are not considering abandoning the DRG program New Jersey has. We would simply be in a position where we would have a two-payer type of system, a Medicare system and a system for everyone else. They would be along the lines we have worked out here in New Jersey.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Yes. Commissioner, you answered most of the questions I was going to ask in your remarks a few minutes ago relative to the quality of care. I understand that some members of the Medical Society of New Jersey feel that the quality of care has diminished and, in fact, that in some cases patients are being discharged earlier than they should be. You made the statement that studies do not indicate that, or have not indicated that. I am just wondering, are there ongoing studies to that effect?

COMMISSIONER GOLDSTEIN: We continue to look at this, since that has been the charge. However, let's switch this around. The one who has the complaint ought to prove his complaint; that is, let any physician in the State, or the Medical Society of New Jersey, come forward to present you with even one documented case. We are talking about over a million admissions in New Jersey. This program has been in effect for three years. We have had some three-million patients who have gone through it. Let them come to you and specifically identify one case where they can demonstrate that the system has adversely affected the quality of care.

Let me just point out where these savings come from. We talk about efficiency. What is efficiency? I mean, a patient is liable to be concerned that he is not getting something done that he otherwise would have had done. That is not what we are talking about. A hospital has a lot of different areas where it can be efficient. One

simple example is: If a person is going to have surgery, the surgeon is going to cross and type some blood. It costs $5.00 every time you cross and type a unit of blood. In the past system you could say, "Okay, let me just order up eight units of blood at $40.00." If he uses three units of blood, the other five units go back to the lab. The next patient, another eight units of blood. Now there is obviously an incentive for the hospital to say, "Order the amount of blood you need. When you see you are going to get to your next unit of blood, call the lab and they will quickly cross and type it and send it up to you." The patient has not suffered; he got exactly the amount of blood he needed. But, the system is no longer paying for unnecessary services when those services are not benefiting patient care. That is the kind of efficiency we are talking about in our system.

ASSEMBLYMAN CUPROWSKI: I think it is fair that if anyone has a legitimate case he bring it forward. I was just wondering, is the Department of Health still going to monitor and study so that this is not going to be abused?

COMMISSIONER GOLDSTEIN: Yes. Let me point out that there is an independent agency monitoring the quality of care in New Jersey, in addition to the Department of Health. These are the professional review organizations. It is a Federal requirement that PROs exist and that they review patient charts. PROs are looking at this. We think this serves our purpose very well, because people cannot claim it is the Department of Health. The PROs do look at this, and within the Department of Health we have a volunteer group of physicians called the Physicians' Advisory Committee. They look at the data the independent organization puts together, and they are the ones who, last summer, issued the statement that they could identify absolutely no impact on the quality of care. The problem continues to be examined very carefully, but it is a moot problem. It just isn't there.

You know, there is a national system with DRGs. It is interesting that as that system went into effect, we heard exactly the same complaint from physicians nationally that our physicians raised early on when this all began. There are a number of studies which show there is no decline in the quality of care, and I don't know of one

single study which purports to show that there is a decline in the quality of care. All the evidence is the other way. I would simply say to look at the motives of those who keep going on about this particular issue. You know, why is it they feel so strongly about criticizing a system in an area where, so far, there has been no evidence? I would suggest it is because there are different sorts of concerns, and you ought to seek to find out what the real concerns are.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: Commissioner, Assemblyman Haines asked a number of questions which I think, quite frankly, could be answered by you. I don't expect you to do it here, but I hope you will answer the questions Assemblyman Haines has raised, both to him and to this Committee, possibly before December 31. I don't think it would take that much time. Do you have a copy of those questions?

COMMISSIONER GOLDSTEIN: No, I don't have a copy; however, I did take notes.

ASSEMBLYMAN HAYTAIAN: Mr. Chairman, is it all right if we make a copy of Assemblyman Haines' questions for the Commissioner?

ASSEMBLYMAN OTLOWSKI: Yes. David, will you please make a copy available for the Commissioner? (affirmative response)

COMMISSIONER GOLDSTEIN: Are you requesting that we reply in writing?

ASSEMBLYMAN HAYTAIAN: Yes, I would hope so, because--

COMMISSIONER GOLDSTEIN: (interrupting) To the Committee, or to Assemblyman Haines directly?

ASSEMBLYMAN HAYTAIAN: Well, to both the Committee and to Assemblyman Haines, because most of the questions are, in fact, directed to the Department.

ASSEMBLYMAN OTLOWSKI: May I make a comment on that, please? Commissioner, now that you have those questions, will you please make sure that we get your response before December 31? As Assemblyman Haytaian indicated, please respond in writing so we can have the answers in front of us.

COMMISSIONER GOLDSTEIN: There is one question he asked which we cannot respond to at this point in time, and that is, "Do you have a contingency plan?" We're working on contingency plans. "If yes, what is it?" We are not sharing any contingency planning at this point in time. That would simply be disruptive and confusing.

ASSEMBLYMAN OTLOWSKI: Are you saying you have no contingency plan at this moment?

COMMISSIONER GOLDSTEIN: It is not developed fully enough to share.

ASSEMBLYMAN OTLOWSKI: But it is not fully developed?

COMMISSIONER GOLDSTEIN: Right.

ASSEMBLYMAN VISOTCKY: But, would you share that with this Committee prior to -- God forbid, you know, hypothetically -- if we do not get the waiver?

COMMISSIONER GOLDSTEIN: Yes. We will share it before December 31. We are simply not prepared to discuss it at this point in time.

ASSEMBLYMAN OTLOWSKI: Commissioner, again, thank you very, very much.

COMMISSIONER GOLDSTEIN: Thank you very much.

ASSEMBLYMAN OTLOWSKI: Commissioner, is Deputy Commissioner Charles Pierce going to supplement anything you have said?

COMMISSIONER GOLDSTEIN: No, sir.

ASSEMBLYMAN OTLOWSKI: Then, that's it from your Department?

COMMISSIONER GOLDSTEIN: Yes, that's it.

ASSEMBLYMAN OTLOWSKI: All right. Thank you very, very much. Is Commissioner Rodriguez here from the Department of the Public Advocate? (negative response) The Commissioner isn't here?

EDWARD H. TETELMAN: No, he has been detained.

ASSEMBLYMAN OTLOWSKI: Are you going to speak for him?

MR. TETELMAN: I can either present our testimony into the record or--

ASSEMBLYMAN OTLOWSKI: (interrupting) I think it is important enough that we ought to hear it. Will you please give us your name and the rank you hold in the Department?

MR. TETELMAN: Sure. I am Edward Tetelman; I am an Assistant Deputy Public Advocate in the Division of Public Interest Advocacy.

I thank the Committee for giving us this opportunity to present this testimony.

ASSEMBLYMAN OTLOWSKI: Do you have copies of the statement?

MR. TETELMAN: Yes, I do. The New Jersey Department of the Public Advocate has been, and continues to be, extensively involved with the health care delivery system in New Jersey. As such, we have been active in the areas of health planning, health policy, and rate setting for hospitals and Blue Cross and Blue Shield. We are especially concerned with assuring that access to quality health care services at a reasonable cost is available to all New Jersey citizens. Thus, we view health care as a right, not a privilege, and we attempt to achieve that goal through our activities.

One aspect of accomplishing this goal is our involvement with Chapter 83. Chapter 83 guarantees the solvency of hospitals in New Jersey, and establishes a system of financial incentives that encourage hospitals to use their resources in a more efficient manner. In addition, Chapter 83 guarantees hospitals reimbursement for uncompensated care and bad debts. Also, because our system controls reimbursement for all payers, it allows the New Jersey Department of Health to limit cost shifting between classes of payers and gives the Department of Health, the Health Care Administration Board--

ASSEMBLYMAN OTLOWSKI: (interrupting) Wait a minute, excuse me. Do me a favor, will you please? Instead of reading the whole statement -- we have the benefit of that since we have copies -- just give us a synopsis. Do it, you know, by referring to your statement here, but let's not read the whole thing.

MR. TETELMAN: I will be happy to.

ASSEMBLYMAN OTLOWSKI: All right.

MR. TETELMAN: We think there are some important benefits to be gained through Chapter 83. For one thing, it reimburses for uncompensated care, which we think is the key element of Chapter 83. The second thing is, it begins to give information -- it produces information for hospital administrators and for physicians on the staff

to begin to use to see what is going on in the hospital. It actually gives you a sense of what kind of resources are being used to deliver care. We think this is extremely important. In the past we haven't known that; now we do know that. Administrators have told us, in our discussions, that the staffs of their hospitals are finally beginning to use this data to make the system more efficient, to take a look at therapies and different kinds of tests that are going on, to adjust the kinds of practices that are going on to make it a better, more cost-effective system, and to increase patient care.

In addition, there is no question that it has helped the inner-city hospitals. In fact, in Paterson, St. Joseph's Hospital, which for 113 years operated in the red and continued to serve poor people when other hospitals were shifting patients to them because they did that, now has the funds to pay for that kind of care. That is extremely important. These hospitals do not have to use the money they get for poor people. Now, they can take the funds they have that may be in excess -- their surplus -- to improve services within the hospitals, and to renovate the hospitals, so we do not see them continuing to deteriorate.

We have been talking to the researchers at Johns Hopkins Medical Services. Johns Hopkins is one of the nationally recognized institutions that looks at hospital costs around the nation. The study they are going to be publishing soon in The New England Journal of Medicine indicates that New Jersey, over the ten-year period from 1971 to 1982, ranked fiftieth in terms of expenses for adjusted admission, which they tell us is the best measure of cost inflation.

ASSEMBLYMAN OTLOWSKI: Will you please repeat that?

MR. TETELMAN: Well, the people at Johns Hopkins have told us that over the ten-year period from 1971 to 1982, the data they have reviewed shows that New Jersey is fiftieth in terms of expenses for adjusted admission, which they say is the best measure of hospital cost inflation. There is only one other entity -- the District of Columbia -- that had a lower cost for adjusted admission than New Jersey. We are eleventh in that study in terms of the uncompensated care we spend on indigent patients. At the same time, our operating margin has

increased. The operating margin of New Jersey hospitals in 1971 was .36; it is now 2.55. That is quite an increase. It shows that the financial situation of New Jersey hospitals has bettered quite a bit.

However, the study also showed that admissions have gone up in New Jersey hospitals. They went up from 119.8 admissions per 1,000 to 145.6 admissions per 1,000. This shows there is something going on in this State that needs to be looked at carefully. Are the citizens of our State a sicker population, since we had such high admissions, or are people being admitted improperly? We need to take a close look at what is going on. These are some of the figures they demonstrated in their study.

While we think we can point with pride to the past, we think we must focus on how we can improve the health care delivery system in the future. We have a few recommendations to make to you today. We made other recommendations to the Health Department on the 1984-1985 regulations they issued. First, we think legislation is needed to allow the Commissioner of Health to close or reduce services at under-utilized facilities. In this State we have some facilities that operate services, for instance, in pediatrics, at 38% utilization capacity. That means that there is under-utilization.

ASSEMBLYMAN OTLOWSKI: How would you deal with that legislatively?

MR. TETELMAN: Well, I think you would amend Chapter 83 in Public Law 136 to say that the Commissioner of Health, through the planning process, would have the authority, based on evidence, to close--

ASSEMBLYMAN OTLOWSKI: (interrupting) Are you making specific recommendations in your statement?

MR. TETELMAN: We are making specific recommendations -- not in detail -- as to how to go about this. The law certainly can be altered to allow the Commissioner to do this through the health planning process.

ASSEMBLYMAN OTLOWSKI: Would you comment on that at another time, and give us more specific information on how you think that can be corrected legislatively while this Committee is still sitting, which, as I said, it will be doing for some time?

MR. TETELMAN: I would be happy to do that. Second, we think the Department of Health should really take a hard look at the health planning regulations. The health planning process is the gatekeeper to this system. It allows services to begin, and it allows services to continue to function. Unless we have stringent regulations to deal with under-utilization of services in this State, we are going to allow unnecessary costs to creep into the system and allow new services to exist when services that may be under-utilized already exist. That would be our second recommendation, and would really be addressed to the Department of Health. In particular, we have just commented on the cardiac surgery regulations in the State. There is under-utilization in those services, yet the regulation which has been proposed by the Department is not strong. We would like to see that strengthened, along with some of the other regulations.

Third, one of the major goals of Chapter 83--

ASSEMBLYMAN OTLOWSKI: (interrupting) Excuse me, there is a question at this point.

ASSEMBLYMAN HAYTAIAN: I'm sorry to interrupt, but when you say we have under-utilization, are you saying there are not enough patients or that the process is just not being accomplished? Why the under-utilization?

MR. TETELMAN: Well, there are two things. First of all, physicians are not referring their patients to our services in the State of New Jersey.

ASSEMBLYMAN HAYTAIAN: Where are they going?

MR. TETELMAN: Oftentimes, they are going to New York and Philadelphia, or to Texas, for that matter.

ASSEMBLYMAN HAYTAIAN: For instance, in the cardiac area, how many hospitals do we have that can do open-heart surgery?

ASSEMBLYMAN VISOTCKY: Two.

MR. TETELMAN: No, no, there are more than that.

ASSEMBLYMAN HAYTAIAN: There are more in New Jersey? How many more?

MR. TETELMAN: I think there are about eight, if I am correct. I can get you that specific figure if you would like me to, Assemblyman.

ASSEMBLYMAN HAYTAIAN: All right. What is the second point?

MR. TETELMAN: The second point is, the services which do exist are under-utilized. There is no reason physicians should not be referring, unless there is some kind of quality-of-care problem in this State, which we would all like to know about. Why aren't they referring their patients to New Jersey hospitals? You have sort of a "You can't have your cake and eat it too" situation. "We would like the service at our hospital, but we are not going to refer our patients to you in New Jersey. We will send them elsewhere until we get the service in our hospital." It is our opinion that you can't have it both ways. We have existing services and they should be utilized appropriately, unless there is a problem. If there is a problem, we should address it.

ASSEMBLYMAN HAYTAIAN: All right. On Page 7 of your testimony you say, "at least 500 procedures per year or two operations per day for 250 days."

MR. TETELMAN: That was a recommendation that was made to the Health Care Administration Board.

ASSEMBLYMAN HAYTAIAN: Are you saying we have enough patients to do that in this State?

MR. TETELMAN: Oh, I think so. I think if you take a look at who got referred out, on top of which-- What it is, is an outside limit to get the existing facilities up to par. It deals with adding additional facilities. What it says is, unless the existing facilities meet those kinds of levels, you should not start new ones. That is what we are saying.

ASSEMBLYMAN HAYTAIAN: Okay. Thank you, Mr. Chairman.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: On that point, first of all, you made reference to the fact that the Department of Health, or the Commissioner, if you will, should be given the authority to close up hospitals which are under-utilizing their beds and under-utilizing services. If hospitals are under-utilizing the beds, if they do not have the patients, if they fall to under 50% or so and they are going

to lose money, wouldn't they close without being directed to do so by the Legislature, the Commissioner, or whomever?

MR. TETELMAN: Well, there are costs which are still passed right through the system -- capital costs, a lot of costs -- that allow them to keep operating although they might lose money on those services. Also, there is some suggestion that you need those services for marketplace reasons, to attract people because you are a full service hospital, etc. What we would like to see, I think, is more joint venturing between hospitals, more cooperation, where one would have this service, and the other one would have that service.

ASSEMBLYMAN CUPROWSKI: You made reference to the fact that doctors refer patients to Philadelphia, New York, and so forth. Is that because perhaps the Certificate of Need process is such in New Jersey that the hospitals cannot be equipped as they are in Philadelphia or in New York? Is that possible?

MR. TETELMAN: I don't think that is possible. If you take a look at the amounts of equipment that pass through the Certificate of Need system, you will see that very little equipment is denied if it can be medically justified.

ASSEMBLYMAN CUPROWSKI: Then why would people be referred to Philadelphia and New York? Do you have any idea?

MR. TETELMAN: I think it is caused by relationships between physicians, where they are friends, or where they know one another. For instance, St. Joseph's Hospital, when it started its service, had a relationship with St. Luke's.

ASSEMBLYMAN CUPROWSKI: Okay, thank you.

ASSEMBLYMAN VISOTCKY: I read in the paper that a doctor said they would rather send patients across the Hudson River, than across the Passaic River to Paterson.

ASSEMBLYMAN FELICE: Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Yes, Assemblyman Felice.

ASSEMBLYMAN FELICE: I have a question. Assuming that the Federal cost figures are correct, that Medicare will spend more money under the DRG program, is it possible for the Department of Health to tighten up the DRG system through regulation to legally qualify for the

waiver extension? In other words, can they lower their costs even by a dollar? Is it possible that they can tighten up through regulation?

MR. TETELMAN: It is our opinion that they can tighten up through regulation. In fact, the third recommendation I am going to make is a shift here to more statewide costs within the DRGs.

ASSEMBLYMAN OTLOWSKI: Are you going to get into that now?

MR. TETELMAN: Yes, I can talk about that right now.

ASSEMBLYMAN OTLOWSKI: Is it all right if he gets into that now?

ASSEMBLYMAN FELICE: That's fine, thank you.

MR. TETELMAN: The third recommendation we make -- and this was one of the goals of the system -- is to shift more of the statewide costs per DRG into the DRGs and away from hospital experience costs, so that the system will then help things to become more efficient. The technical term is "the coefficient of variation," which is to have that shift so that hospitals throughout the State ultimately end up with an 80% statewide cost in our DRGs and a 20% historical hospital cost in our DRGs. That was one of the goals, and we would like to see some movement continuing that way. We recommended to the Department of Health that they shift this year, Fiscal Year 1985, to a 50/50 arrangement on the coefficient. So, 50% would be statewide, and 50% would be based on hospital cost experience.

Fourth, we recommend that legislation be enacted to broaden the range of providers that are presently unregulated. We have a lot of regionalized services or providers outside the Certificate of Need system that purchase things like NMRs which should be regionalized. We think everyone should be treated equally so that the competition is equal, and so that the social burden the hospitals have would also follow anyone else who would be providing that type of service. From what I understand, there will be legislation introduced to address that issue.

Fifth, in light of the discussions surrounding the waiver, we would like to see some more analyses done concerning the efficiency of hospitals, the costs of hospitals, the patterns of admission practices, and other relevant matters, to try to quantify what the costs are and what is actually going on.

Finally, we recommend to the Legislature, government agencies, health care providers, and other people who are interested in health care in terms of our system, that we begin to take a look at the data to see what that data shows. For instance, in Salem County, we know that studies have shown that we have one of the highest rates of bladder cancer in the country. It has been traced back to the fact that the dye industry existed there, and that caused the rates to go up. What is DRG data showing? Where are the people coming from who are going in for specific operations or specific problems? Is it exposure to toxic substances in the State? Is it poor nutrition in some areas of the State? What is it? Let's take a look at that data. It should begin to point the way to solutions so we can trace back to find out what those problems are and what the causes of those problems are. We can then correct things to prevent the problems and can develop a preventive strategy in the State so that costs won't be so high and people won't end up in hospitals.

In conclusion, while the verdict on the success or failure of Chapter 83 certainly has not been written yet, it has demonstrated some tangible benefits such as uncompensated care and increased dialogue among providers and hospital administrators. Also, it has certainly made New Jersey hospitals more solvent. It is our opinion that to prove the health care delivery system, we have to continue to work with the system itself, and look for ways to improve it so we can reach our goal of achieving an accessible system of health care which efficiently provides quality service at a reasonable cost. Thank you.

ASSEMBLYMAN OTLOWSKI: In his testimony, the Commissioner said that no hospital is losing money. It came to our attention when Assemblyman Haines was testifying that a particular hospital to which he was making reference said that it lost money. So, there is a contradiction of terms. Then I asked--

ASSEMBLYMAN VISOTCKY: (interrupting) He said they would lose money.

ASSEMBLYMAN OTLOWSKI: Oh, he said they would lose money? I thought he said they had lost money. In any event, in those cases where hospitals complain that the system affects them adversely, and

even when they complain that they are losing money, there is a mechanism for appeal. Do they involve the Public Advocate's office in that kind of a situation, or do they usually come before the Commissioner with their own staff people and their own attorneys?

MR. TETELMAN: They come in with their own staff people, but we are also involved at the Hospital Rate Setting Commission and we participate in those hearings.

ASSEMBLYMAN OTLOWSKI: Oh, you do participate?

MR. TETELMAN: Yes, we do.

ASSEMBLYMAN OTLOWSKI: So, you are privy to the whole thing. As a matter of fact, you are practically sitting there as a monitor.

MR. TETELMAN: We are sitting there at the rate setting hearings.

ASSEMBLYMAN OTLOWSKI: Okay, that answers my question. Assemblyman Vistocky?

ASSEMBLYMAN VISOTCKY: Don't you think New Jersey is becoming a secondhand state when compared to New York and Pennsylvania? You talked about a children's hospital in New York, and you said that Philadelphia recommended-- We do not really have an outstanding situation with a hospital where we can say, "This is our children's hospital, the only one, and a big one for research. It is for heart operations and everything else." We are trying to have a dialysis machine in every hospital in the State of New Jersey -- instead of having to wheel one around -- where doctors can participate. It was said originally that we should be more cooperative and work together more. I think what we have here is a conglomerate, with every hospital wanting to be the one hospital that can do everything. I think we should have more specialized hospitals in the State. It would be fruitful for all of us and would provide cost savings of a lot of money to a lot of people.

MR. TETELMAN: We think regionalization is a very, very important concept.

ASSEMBLYMAN VISOTCKY: We all agree with that. I don't want to let you go yet; I have another question. Do you know of any plan to deal with indigent people in the State in private uncompensated health care? Do you know of any plan the Administration has?

MR. TETELMAN: I do not know of any plan the Administration has to deal with the indigent or uncompensated care should we not get the waiver. However, I do know this: We have pending legislation before the Assembly -- which this Committee passed -- concerning the Medically Needy Program, which would certainly help to provide and secure funds on a 50/50 match with the Federal government that would help to cover those uncompensated care cases, should we pass it. I certainly would encourage the Legislature to act on that.

ASSEMBLYMAN VISOTCKY: Is there anything through private health services plans?

MR. TETELMAN: To my knowledge, there is not.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski, do you have any questions?

ASSEMBLYMAN CUPROWSKI: Yes. Mr. Tetelman, I think you made a reference to regulating unregulated health care providers. Can you elaborate a little bit more on that?

MR. TETELMAN: Yes, I can. When the issue of unbundling of service -- moving services out of hospitals -- came up, the State planning bodies and other interested parties got together and began to look at what kind of an effect this would have on the system. One of the things that came out was that there were providers outside of the hospital system that were providing similar services to what the hospitals did, but they were totally unregulated, thereby undercutting the utilization of those hospitals without having any of the social responsibilities of the hospitals.

What we proposed, and what the State Health Coordinating Council has supported, is that we provide legislation to begin to regulate those regionalized services, like the nuclear medical imaging services and other types of out-patient regional services, for those providers who want to provide services outside hospitals, to bring them within the Certificate of Need system so that they can present requests or Certificates of Need just like any other provider. That would put everyone on an equal basis, and the other things, such as a percentage of their service going to serve the poor, will follow them out to the community. If they are going to deliver the service, they should have

some of the social responsibility too, not just the cream off the patients.

ASSEMBLYMAN CUPROWSKI: All right, thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: I guess the fourth recommendation is the one that Paul touched on. You have indicated that you want to broaden some of the areas that are not regulated, or which are unregulated at this point. You said legislation is being prepared, or is it in the hopper?

MR. TETELMAN: I know we saw a copy of proposed legislation at the State Health Coordinating Council because we recommended it to the Department of Health. From what I understand, the Department is going to eventually present it.

ASSEMBLYMAN OTLOWSKI: Is that in our Committee now?

MR. TETELMAN: I'm not sure; I don't think so.

ASSEMBLYMAN HAYTAIAN: No, that is why I asked the question. Also, are you going to put the medical profession in that category?

MR. TETELMAN: The members of the medical profession who enter the corporate practice of medicine and buy these types of regionalized equipment, yes, we would put them in there. Now, there have been discussions with the Medical Society of New Jersey concerning this legislation. It is my understanding that they have agreed to this particular type of regulation.

ASSEMBLYMAN HAYTAIAN: Are you saying, for instance, that the magnetic CAT scan type of machinery that is out today should be regulated, that is, the medical people who take part in that program?

MR. TETELMAN: Yes.

ASSEMBLYMAN HAYTAIAN: Why?

MR. TETELMAN: Well, because it costs so much, number one.

ASSEMBLYMAN HAYTAIAN: What?

MR. TETELMAN: It costs so much.

ASSEMBLYMAN HAYTAIAN: It costs so much, but it does an excellent job.

MR. TETELMAN: Right, but the question is, if we have a whole bunch of them out there and we-- for instance, if we leave a service

in a hospital, if a hospital gets an NMR, and across the street a group of doctors form a corporation and start the same kind of service, what ends up happening is, they do not have the same kind of costs that the hospital does because the hospital has to take care of indigents and it has overhead. They can just provide the service and cream off a lot of the patients who would normally go to the hospital. What we are looking for is to utilize this service. We want to be assured there are enough services throughout the State. We are not saying to limit them; what we are saying is, if you are going to start the service, you should have similar social responsibilities.

ASSEMBLYMAN HAYTAIAN: Yes, but what you are saying, in essence-- Pardon me, Mr. Chairman, because this is very important. I think this will be the next decade of medical history in this area. What you are saying is, restrict competition, thereby possibly keeping prices where they are. If you have competition, you could bring prices down.

MR. TETELMAN: Well, that certainly hasn't been proven yet. What ends up happening--

ASSEMBLYMAN HAYTAIAN: (interrupting) Yes, but you are not giving it a chance to be proven by saying "regulate it." I can't understand that philosophy.

MR. TETELMAN: It doesn't show a system's cost saving, because it will exist in two places. One will be under-utilized, and one will be making money perhaps. We don't even know. When CAT scanners came out and physicians put CAT scanners in their offices initially and then the hospitals got them, what ended up happening was that a lot of the physicians got stuck with the cost of the CAT scanners, and people did not end up using them. That is one of the things.

ASSEMBLYMAN HAYTAIAN: If you take CAT scans and NMRs at the present time, I would take an NMR diagnostic treatment anytime compared to a CAT scan.

MR. TETELMAN: They are just slightly different things, but in our State I think we are going to see good--

ASSEMBLYMAN HAYTAIAN: (interrupting) Less risk.

MR. TETELMAN: Also, we are going to see good regulation coming out on this. This is a very expensive piece of equipment, as you know. We want to make sure it is used cost effectively.

ASSEMBLYMAN HAYTAIAN: Thank you, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: I can't resist this question following Assemblyman Haytaian's questioning. You're not talking about having such wonderful regulations that you'll do away with a competitive spirit that should exist in hospitals, are you?

MR. TETELMAN: Absolutely not. You'll notice it only talks about regionalized services that would just shift costs between different provider groups.

ASSEMBLYMAN OTLOWSKI: I just wanted to have the comfort of that answer.

ASSEMBLYMAN HAYTAIAN: I am not that comfortable with that answer.

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice?

ASSEMBLYMAN FELICE: Yes. I can't miss this chance to bring up a very valid point in light of the conversation and the statistics. Recently we have been holding meetings of the Advisory Committee on the asbestos problem in the State of New Jersey. It is interesting to note that one of the reasons there was so much chaos, that is, not really knowing the proper testing or standards for asbestos removal, was the fact that the State of New Jersey does not own an electronic microscope. If it wasn't for the fact that individual corporations and individual testing labs have electronic microscopes, there would be no way to have a standard which could eliminate the mass confusion and the crisis which took place.

I don't think at any time that any department or anyone else should over-regulate corporations, individuals, or even institutions which have facilities, whether they be diagnostic electronic systems, electronic microscopes, or any other type of scan machinery. I think that is important, because we do not want to discourage individuals, companies, corporations, or universities from having equipment that the State can utilize without going out and spending hundreds of millions of dollars.

One of the reasons we had the problem with standards and certain specifications for the removal of asbestos was because the New Jersey Department of Health did not have access, from within, to an electronic microscope to set the standards in the State; however, there was access to such equipment through individuals, corporations, and testing laboratories. So we must be very careful not to over-regulate to the point where the facilities are no longer there for our use.

MR. TETELMAN: We agree with you. That is why we are using a narrow approach in addressing this issue.

ASSEMBLYMAN OTLOWSKI: Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Since the Public Advocate's office is always worrying about other things that have happened, do you have a plan or is there a plan by the Public Advocate to shift the cost of these uncompensated claims to the private cost payer?

MR. TETELMAN: Not at this time. We support the Department of Health's activity to get the waiver.

ASSEMBLYMAN VISOTCKY: Yes, but can't we, again, project and ask, "What if we don't get the waiver?" Are we talking about having a plan by the Public Advocate's office to tell us whether this is the strategy that should or should not be used? Or are we going to wait until the eleventh hour and say, "Gee, we didn't do anything about it"?

MR. TETELMAN: We will be happy to look into it and try to come up with some suggested solutions should that happen, if that is the pleasure of the Committee.

ASSEMBLYMAN VISOTCKY: I think your testimony today should have included some kind of alternate plan. Again, are you going to wait until after it happens and then say, "We should have done this"? How, then, would you be helping this Committee? How would you be helping us to either propose legislation or put a program into effect? We hope you won't wait, again, until after the fact. I am serious.

MR. TETELMAN: I understand that you are serious. It is like everything else. You can do contingencies for everything. First, we have to support the Department in getting this waiver before we say, "Here's the plan." That would make it easier for HCFA to say, "Well,

we have already got these contingencies in place, so we don't have to worry that much about what might happen." If you would like us to look into this, we will be happy to get together and do so.

ASSEMBLYMAN VISOTCKY: Oh, I think it is your job. It is not for me to tell you what to do; you should do it anyway. My point is that I do not want to sit here as a member of this Committee while you testify before us, telling us all these nice, glorified things, and then next week have you unexpectedly say, "Boom! Here's a plan." We would then be sitting here saying, "He testified before us only last week, and he didn't say anything then about having an alternate plan." I would be embarrassed if that were to happen.

MR. TETELMAN: As would we, I should think.

ASSEMBLYMAN VISOTCKY: You should.

MR. TETELMAN: We would.

ASSEMBLYMAN VISOTCKY: It would be embarrassing.

ASSEMBLYMAN OTLOWSKI: Thank you very much. You have been very helpful. Of course, I don't think Assemblyman Visotcky was trying to be facetious, because that would be difficult. (laughter) In any event, what has been bothering him -- as a matter of fact, what has been bothering the Committee -- is that we don't want someone coming out of left field with a plan they have been sitting on in case everything else fails. Then, after we have conducted hearings and asked for every bit of information and material we could get, all of a sudden, out of nowhere, a plan is sprung on us. I think Assemblyman Visotcky was expressing the collective view of the Committee as he pursued that line of questioning.

MR. TETELMAN: We take his suggestion seriously.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MR. TETELMAN: Thank you.

ASSEMBLYMAN OTLOWSKI: May we next hear from Mayor Joseph Frankel, please?

J. JOSEPH FRANKEL: I want to thank you for that introduction, Mr. Chairman. May I ask you, please, to call Assemblyman Michael Adubato, so that I may use that same introduction whenever I appear before his Committee? (laughter) It is a pleasure to be here this morning. I am

Joe Frankel, the Mayor of Eatontown, but I am here wearing a different hat today, that of the Vice President of Government Relations with the Prudential Insurance Company of America. I would like to introduce to the Committee my colleague, Marsha Rosenthal, the Director of Health Policy Coordination for Prudential.

I will be brief, Mr. Chairman. I have presented you with printed copies of our testimony, and I would like to refer to a few points from therein. First, we strongly support the DRG system, and the continuation of the Federal waiver of the New Jersey program.

Second, we agree with the points that have already been made regarding efficiencies that have been created in the system by the DRG program. I want to echo the comments made by Mr. Tetelman of the Public Advocate's office when he talked about the positive impact this has had on inner-city hospitals. That, we feel, is very important.

The third point in my testimony deals with equity, which is also very important. Current law requires all patients to be charged on an equitable basis, regardless of who provides their coverage. This results in greater private-sector competition among the Blues, insurance companies, HMOs, and employer and union health benefit plans. We believe this competition will be extremely beneficial to all New Jersey citizens.

I have a suggestion that I would like to leave with you. It is in my printed testimony, but I will be brief. There has been a misunderstanding over the years about the DRG system; we think this might help clear it up: We recommend that the State develop a clear, explicit monitoring and evaluation process for the DRG system. A limited set of key figures that would show whether or not the DRG program is working to control costs could be compiled and released to the public on a regular basis -- just as is done with the U.S. Consumer Price Index. This, we feel, would be helpful. If the figures were released once every six months, they would go a long way toward clearing up the misinformation about the DRG program.

Let me turn to the Medicare waiver for just a moment. We feel this is also very important. Without the waiver, the two Federal health programs cannot participate in the New Jersey rate-setting

program, and they will not participate as equitable payers. This means that patients not covered by Medicare or Medicaid will face additional costs added to their hospital bills, to make up for the Medicare-Medicaid shortfall. It will be more difficult for hospitals in the State to respond to cost-containment incentives in the DRG program if they are faced with two separate payment programs: one for private-sector patients, one for public-sector patients.

We believe the State has done a credible job in its application for the Medicare-Medicaid waiver, and we hope the Federal department will respond soon in granting it. We have been involved with this for a long time. I remember appearing long ago, when S-446 first went on the books. We think our State -- as Commissioner Goldstein said earlier -- has been a pioneer in developing this whole program. People have worked in a cooperative way to get it started, and I think they should continue to do so. I want to say to you, Mr. Chairman, that it is very wise of this Committee to discuss this. When you clear the air, it makes for a much better system. I want to thank you for allowing us to participate here this morning.

ASSEMBLYMAN OTLOWSKI: Mayor, thank you very much. Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Sure. Mayor Frankel, if we should lose the waiver, would the insurance companies pick up some of the costs of our indigent and uncompensated claims?

MAYOR FRANKEL: I think that would place us back where we were before the whole system came into place. Unfortunately, there was a wide spread between what private-pay patients and others were paying. I hope it does not come to that. Marsha, do you want to add anything to what I have said?

MARSHA ROSENTHAL: No, I think you have covered it.

ASSEMBLYMAN VISOTCKY: How much of a problem -- moneywise -- are we talking about ?

MS. ROSENTHAL: The Commissioner said $50 million, so we are talking about $50 million worth of problems.

ASSEMBLYMAN VISOTCKY: Well, I think it is more than $50 million. Are you talking about only $50 million?

MS. ROSENTHAL: I think the total figure is around $90 million, but the Commissioner said he was extracting something from that figure. I have been working with the $90 million figure. I believe it to be a good one to start with. We would have to handle it, if it came to that. The cost would then be passed along to the policyholders.

ASSEMBLYMAN VISOTCKY: You people don't have any idea how much it would cost the private payers -- other than what the Commissioner said?

MS. ROSENTHAL: We are working with figures that were released by the Department of Health.

ASSEMBLYMAN VISOTCKY: Suppose those figures are higher?

MS. ROSENTHAL: We will not know that until after they are passed along to us.

MAYOR FRANKEL: I think the problem, really, is that we could revert to the tremendous spread we once had. Before the 1978 law, there was a 20- to 25-percent spread between what private-pay patients and others were paying in New Jersey. We could end up in that same kind of problem area -- maybe not overnight, but certainly in a period of time.

ASSEMBLYMAN VISOTCKY: That would naturally increase the cost for everyone else.

MAYOR FRANKEL: It would destroy one of the key points in the whole program, that of equity. Why should our policyholders have to pick up the lion's share of that tab?

ASSEMBLYMAN VISOTCKY: But, eventually, if we should lose it, there would be no question about it.

MAYOR FRANKEL: That is why we are strongly advocating that it not be lost. But, you are right.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Thank you, Mr. Chairman. Mayor Frankel, let us, for a moment, assume the worst-possible scenario: If all of the costs were to shift to the insurance companies, what would that mean to the average policyholder -- in dollars -- for a month or a year? Would you make an estimate?

MAYOR FRANKEL: It would have a dramatic impact upon our policyholders. I cannot sit here today and give you exact numbers; however, the point I was making to Assemblyman Visotcky is that it would revert to a non-equitable situation. In a competitive market, anytime your prices are higher than those of someone else you are not going to get the business you are seeking. It would hurt the individuals and our company.

ASSEMBLYMAN CUPROWSKI: Has your company done any studies, relative to past increases? For example, what percentage of policyholders drop out, as a result of getting a 20-percent increase over the years? Are there any figures, or have there been any studies done, on that? Hypothetically, if we were to have an increase now -- whatever it might be -- could we project that "X" number of people would no longer be able to afford it?

MAYOR FRANKEL: I do not know about that. I do know, however, that the area of mandated benefit legislation, which we keep running into, is driving people to self-insure. Marsha, would you like to respond to that question?

MS. ROSENTHAL: I don't think we have done any specific studies. We see the results in our marketplace. The example Joe just gave you is relevant. As premium costs increase, policyholders self-insure; they drop their insurance coverage. There are reasons why we prefer they not do this. One of our key concerns is that small groups would drop health coverage altogether; that would put these people back in the individual marketplace.

MAYOR FRANKEL: Would you define for the Committee the size of a small group?

MS. ROSENTHAL: It varies from company to company, but for the Prudential we are talking below 100 persons.

MAYOR FRANKEL: I think that definition is relevant to your districts. If you have small companies -- not giant companies -- with under 100 workers, that is a part of what we are talking about.

ASSEMBLYMAN CUPROWSKI: I am concerned that if we have the loss of a small company -- of the individual -- due to an increase in premiums, they will, in effect, become indigent, and someone will have

to pick up the cost somewhere along the line. It will come back to the municipalities, the State, and so forth. That is a real concern.

MAYOR FRANKEL: I think that tracks what the Commissioner said earlier, about more and more people putting more and more of a burden upon the hospitals, thus creating a vicious circle. It could become a big problem for this State.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN HAYTAIAN: Would there be a strategy, if need be, by the insurance companies -- to offer a different plan with Blue Cross for hospital care on a sliding scale -- to pick up some of this?

MAYOR FRANKEL: I don't know the answer at this point, but we would certainly have to put our heads together and see where we were going. We are in business, and we want to stay in business.

ASSEMBLYMAN FELICE: Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice?

ASSEMBLYMAN FELICE: One of the most valid points, made by Mayor Frankel and some of the others, is that the statistics and accumulation of actual facts and figures should be continually updated. Many of the states throughout the country were looking at different programs -- the HMOs and DRGs -- but there was insufficient time and too few statistics to prove what has happened in the states that have the DRG program.

One of the interesting things brought out at the national meeting is that it appears that -- now that facts and figures are coming in -- other states, such as Florida and certain ones in the Midwest, are more favorably fingering the DRG programs and are switching to the New Jersey-type plan or a similar one. That is the key. The more statistics, facts, and figures we can get, the more honestly we can decide the best direction in which to go. That, I think, is a great idea.

MAYOR FRANKEL: Let me say this, Assemblyman Felice. Our company has always prided itself on being a resource for any legislative body or committee. Marsha Rosenthal and members of her staff have worked closely with the Department of Health and the Hospital Rate Setting Commission, but we are not going to inject

ourselves into the process unless it is requested of us. If we are asked, we will try to help in any way we can, in as objective a manner as possible. We have always prided ourselves on that, and we will continue to do so.

ASSEMBLYMAN OTLOWSKI: Mayor, let me ask you something that no one has asked yet; I am serious and earnest about this. Would you please -- and I am sure the Committee would be delighted to receive this kind of cooperation -- specifically outline an approach detailing how it should be done? Then, using the brains you have available in your company, would you further indicate how it should be implemented? What I am asking you to do is precisely what you just spoke of. You have access to a resource facility. As a matter of fact, I like to think there are a heck of a lot of brains there. I am asking for the use of the facility and those brains. May we have the benefit of that?

MAYOR FRANKEL: Absolutely. We will be happy to do so, just as long as I understand exactly what you are looking for, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: We will be talking to you more specifically. David Price, Chris Simon, and Assemblyman Felice will be speaking to you. As a matter of fact, I will be talking to you from time to time. Thank you very much.

One other thing before you leave. When you are short of money, it is easy to pass the cost on to the next guy. Let's assume the worst: that this thing fails; that it goes down the drain; and, that we are faced with this tremendous cost that has been talked about, but has not yet been pinpointed. People are talking $50 million, $90 million, maybe as high as $150 million. That being the case, how could you shift such a cost onto people who are a part of your system? That would not be inequity; that would be supreme gall. I am not only talking about your company, but any company which carries that kind of insurance.

MAYOR FRANKEL: Well, there is a gentleman in the audience today, Edwin Soeffing of the Health Insurance Association, who is on your list, Mr. Chairman. We are a member of his association, as are many other companies. I am certain that companies with people who

carry health insurance feel exactly the same way as we do. It would create a bad situation for us.

ASSEMBLYMAN OTLOWSKI: Mayor, thank you very much.

MAYOR FRANKEL: Thank you.

ASSEMBLYMAN OTLOWSKI: On Mayor Frankel's recommendation, may we hear from Edwin Soeffing, the counsel for the Health Insurance Association of America? Edwin, when you get seated will you introduce yourself, and your battalion there, please? (motions to two people who accompanied Mr. Soeffing to the witness chair)

EDWIN SOEFFING: I will. My name is Edwin Soeffing. I am counsel for the Health Insurance Association of America. I brought a couple of colleagues with me today who are experts in their field, and after hearing some of the questions that have been asked, I am glad I did. On my far right is Anne Grabois, Associate Director of our Consumer and Professional Relations staff; on my immediate right is Stanley Peck, Director of Field Operations for our Consumer and Professional Relations staff.

ASSEMBLYMAN OTLOWSKI: Before we do anything else, and while this subject is fresh in our minds, will you address the question that Mayor Frankel was just talking about -- about anticipating the worst? The cost has to go somewhere. Some people are advocating that the insurance companies should pick it up. Will you address that for a moment?

MR. SOEFFING: Certainly. I do not think we have a magic answer, but if we have a plan it is the same as the one outlined by Prudential. If the waiver is, indeed, lost -- and I don't think that is going to happen; we certainly hope it is not; most of our efforts are being directed toward helping the State save the waiver -- we think the best plan is the kind Prudential proposed to you. It is not a specific plan but, rather, a generalized answer. We will work with you. We will give you all of the talent -- from within our association and other member companies -- we can assemble, to work with you, the Department of Health, and the Administration, to see that any regulations promulgated, or any further reference under S-446, or otherwise, come out as equitably as possible. We will join with Prudential to work with you and others in the State on this problem.

ASSEMBLYMAN OTLOWSKI: Again, if the costs shift, as Assemblyman Visotcky and other members here have discussed, what would happen to the insurance companies that would be faced with the additional cost? It would be shifted to the policyholders, isn't that so?

MR. SOEFFING: It is my understanding that you are saying, "Let's take the worst case and assume there is cost shifting." Then, yes, that is what is going to happen. Companies have been known to take losses in this business; not every year is a profitable one. I could show you figures from some pretty scary years in the past where the industry, as a whole, and perhaps some companies in this State, actually took some red ink. If you can't make a dollar, you at least like to break even; and to the extent you can, you are going to pass it along to the policyholders. Certainly, then, it is going to affect -- down at the bottom line again -- consumers, individuals, and real people. We are not talking about pie in the sky.

ASSEMBLYMAN OTLOWSKI: Let us look at it from another point of view. Industries now, in their contracts with labor organizations, want to get out of carrying health policies for many of their employees because the costs are increasing. This would only add to that. Am I correct?

MR. SOEFFING: You are correct. If I am not mistaken, when the auto industry was in the depths of its problems a year or two ago, perhaps a little longer, the first thing they tried to do when negotiations came up was to renegotiate some of those health insurance benefits.

ASSEMBLYMAN OTLOWSKI: Thank you; I wanted to bring that into perspective. Would you go on with your-- Wait just a moment, please. (confers with Committee aide) Would you summarize your statement, and just refer to your written text, please?

MR. SOEFFING: Yes. I am going to try to cut it down. I will do the same thing Mayor Frankel did. I will then turn it over to the experts. I will answer any questions that I can, and I will ask them to answer the rest.

Basically, the HIAA -- the Health Insurance Association of America -- is a trade association that represents more than 300 major insurance companies throughout the United States. More than 100 HIAA health members do business in New Jersey. We are a pretty big factor. As of 1982, our figures show that our private health insurance carriers paid over $893 million in accident and health insurance benefits to approximately 2.5-million people during that year.

I won't go into how the system was set up in 1978, Chapter 83, or the subsequent phasing in of the DRG system; I will, however, give you a feeling of our thoughts about it. You want to know what we are doing to try to help save the system. Our president, Jim Moorefield, who is located in Washington, wrote to Federal HHS Secretary Heckler, along with the Governor of this State, on behalf of the waiver application. Mr. Moorefield referred to New Jersey as one of the four states which is currently implementing an all-payer prospective hospital payment system, and noted that New Jersey has helped achieve significant savings for Medicare and the private sector during the first four years of the program. So we are quite disappointed by the November 7, 1984, letter from HHS, and we hope they can be persuaded to change their position in current negotiations with the State.

We say this because we believe that, basically, the DRG system is beneficial to the State. It establishes a uniform payment system for all hospitals and payers, and clearly defines the hospitals' full financial requirements. We do not like to see cost shifting because, as you know, this creates perverse incentives. When it occurs, some payers are able to negotiate exclusions of payment for such things as bad debts, charity care, working capital, and research and education costs. So we would like to avoid cost shifting, if we can.

We believe that you have been able to do some of that. We have seen the favorable impact of the DRG system. Hospital management appears to be working with their clinical staffs to deliver health care more effectively and more efficiently. We see this as beneficial, and we want to make one point. Like Mayor Frankel, we are strongly in

favor of the DRG system. We are also strongly in favor of retaining the Medicare waiver. We will do what we can to help the State, in any way, to achieve those two objectives.

Let me then jump to the end of my statement, and say that we see a couple of areas which could be improved. We will make a couple of suggestions. It is imperative, in our opinion, that the Department of Health, for example, try to identify and produce the types of data reports which will be beneficial in evaluating the system's strengths and weaknesses.

Moreover, we believe the present utilization review system could be improved. Current estimates, from the New Jersey Department of Health and the New Jersey Hospital Association, indicate that approximately $10 million is being spent by all payers for utilization review.

Previously, regulatory recommendations had been made to strengthen the process, but the recommendations were withdrawn by the Department of Health prior to review by the Health Care Administration Board. We suggest, as one area for improvement, that the Department reconsider its position, and give further consideration to improvement of the current utilization review system.

Finally, we suggest that the Department of Health might want to establish a data-reporting system that would allow its staff, the Rate Setting Commission, and other interested parties -- including this Committee -- to accurately monitor and evaluate the DRG reimbursement program. Aided by such data, we hope further improvements to the system would be made that would help lighten the financial burdens of all of us -- the payers, the hospitals, and the public.

ASSEMBLYMAN OTLOWSKI: Excuse me, at this point. Is this what Mayor Frankel and Assemblyman Felice were talking about?

MR. SOEFFING: I believe so. I think that, to a certain extent, the Public Advocate was also talking about it.

ASSEMBLYMAN OTLOWSKI: Are you talking about the monitoring, reviewing, and semiannual report, to give people an idea of the good and bad aspects of the program, how it's actually working, and where it needs a little tuning up?

MR. SOEFFING: Sure. If we know where the problems are, we can then suggest solutions. We first have to isolate the issues and problems.

That's it, unless you have any questions.

ASSEMBLYMAN OTLOWSKI: Since we are talking about that, just let me skip around for a moment. Assemblyman Felice, do you want to follow up on that?

ASSEMBLYMAN FELICE: No, I think he hit it right on the head. That is exactly what we are trying to define. He sounds like an engineer -- like me -- in that, before you can solve a problem you must find the problem. That has been the process in the DRG program in New Jersey, as it has been in other states that have had it. There is no question that there are shortcomings in any new program, including the one New Jersey undertook.

But, once these problems are discovered, they can be resolved, in most cases, to the betterment of the people in health programs in the State of New Jersey.

ASSEMBLYMAN OTLOWSKI: Thank you. Let's get back to Assemblyman Visotcky. Assemblyman, do you have any comment?

ASSEMBLYMAN VISOTCKY: Yes. You make reference in your written testimony to the letter from Carolyne K. Davis of the HHS Administration in Washington.

MR. SOEFFING: Yes, sir.

ASSEMBLYMAN VISOTCKY: Did you see that letter?

MR. SOEFFING: Yes, I have seen the letter.

ASSEMBLYMAN VISOTCKY: How were you able to see the letter, when we were not?

MR. SOEFFING: I don't know. I really don't know how we got the letter, but I do have a copy in my possession. I do not have it with me today; let me make that clear.

ASSEMBLYMAN VISOTCKY: That is very interesting. (to Committee members) That is the letter we asked the Commissioner about. I am surprised that the Legislature doesn't have it, yet other people do.

ASSEMBLYMAN OTLOWSKI: Excuse me, Assemblyman. Let me do this. I am going to ask Chris Simon, a member of our staff, to get us a copy of that letter immediately, and make it available to all members of the Committee. (confers with Chris Simon, who then leaves Assembly Chamber)

ASSEMBLYMAN VISOTCKY: How is she going to get it?

ASSEMBLYMAN OTLOWSKI: That's her business. (laughter) She had better get it. (more laughter) I'm sorry.

ASSEMBLYMAN VISOTCKY: That is the only question I have right now. I just don't see how other people are privy to information that we, as legislators, don't even have.

MR. SOEFFING: Let me answer.

ASSEMBLYMAN OTLOWSKI: Excuse me, the point you make, Assemblyman, is a valid one, and I am going to pursue it and see that it is done. As a matter of fact, I am serious when I say I want Chris to pursue it and make copies of the letter available to the members of the Committee, as quickly as possible; however, I didn't mean that she should run away from us.

ASSEMBLYMAN VISOTCKY: (laughing) She has to go find the letter.

ASSEMBLYMAN HAYTAIAN: Mr. Chairman, if I may, I think that, in all due respect, and I am sure you would agree, when you have this type of correspondence it is generally handled through the Administration in the State, rather than through the Legislature.

ASSEMBLYMAN OTLOWSKI: Assemblyman, I took the microphone away from Assemblyman Visotcky because I didn't want to make an issue of this. That is why I acted immediately.

ASSEMBLYMAN VISOTCKY: Thanks a lot. (laughter)

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: I have no specific questions. I only hope that, if the suggestion is to inform the public of the benefits and statistics relative to the DRG program, it will not be as complicated as the CPI. Most people do not understand that. It should be in plain, simple language, to enable people to understand how much money they are paying out of their pockets. They don't understand all

of the formulas that go into the CPI and that, hopefully, will not go into whatever information might be forthcoming from the Department of Health.

ASSEMBLYMAN OTLOWSKI: Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: No, I am fine.

ASSEMBLYMAN OTLOWSKI: Assemblyman Felice?

ASSEMBLYMAN FELICE: Fine, thank you.

ASSEMBLYMAN OTLOWSKI: Just one other thing. We are, undoubtedly, going to be talking to you again, either individually or as a Committee. We are going to ask for your help because of your specific knowledge, and because of the kind of organization you have. You would make yourself available for that, wouldn't you?

MR. SOEFFING: Certainly, as will the two people on my right, and anyone else from within the organization who could be of help. You have our promise of cooperation. Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much. May we now hear from Louis Scibetta? Oh, who are the people upstairs there? (calls attention to a group of young onlookers, above in the Assembly Gallery) They are students. Who is the teacher in charge? Is there a teacher in charge? (affirmative response from children) Would you please identify yourself and the school you represent?

VOICE FROM ASSEMBLY GALLERY: I am Rebecca Kniesler from Holmdel Village School.

ASSEMBLYMAN OTLOWSKI: Could we get the children to stand, so they could be recognized, and we could applaud for them? (applause as children stand) Children, would you sit down now? We have seen enough of you. (laughter)

Children, this is a Committee hearing. We are the Committee on Corrections, Health and Human Services. We are discussing a very serious problem, one that could face the State. We will be doing so for some time. We will listen to the experts and to those who are not such experts. In fact, we will listen to anyone who wants to be heard, in an attempt to get ideas on how to solve the problem we are facing.

We appreciate the fact that you are here. As legislators, it is always nice to see young people who are interested in seeing what we

are doing. As a matter of fact, this is primary learning for you, and the best way to learn is by seeing and taking part. It is good to have you as a part of our hearing this morning. We welcome you.

Now, to get back to the business at hand. (turns his attention to the next witness) Would you identify yourself for the Committee, please?

LOUIS P. SCIBETTA: Yes, Assemblyman. I am Louis Scibetta, President of the New Jersey Hospital Association. I am pleased to introduce Craig Becker, the Assistant Vice President of Government Relations for our association.

ASSEMBLYMAN OTLOWSKI: Do you have written testimony?

MR. SCIBETTA: Yes, we have provided the Committee with written testimony, sir.

ASSEMBLYMAN OTLOWSKI: (to David Price, Committee aide) How many pages are there?

MR. PRICE: Seven pages.

ASSEMBLYMAN OTLOWSKI: Will you talk extemporaneously, and just refer to your written testimony, so that we may get on with this?

MR. SCIBETTA: I would be happy to do that. First of all, I have heard several numbers bandied about this morning. I thought it might be important, for the record, to indicate that the hospital industry in this State represents more than a $3-billion industry, and approximately 40-percent of that figure is represented in the amount of payments received from the combined Medicare-Medicaid system -- predominately from the Medicare system. The impact of that money is the issue around which many of the conversations today have bandied.

I would like to say that I fully support the Commissioner of Health in his statement that New Jersey hospitals are more efficient. I think he should be commended for saying that in public. I believe it is a statement that is too often neglected, and is, perhaps, one of the reasons we find ourselves in the ambivalent position of wondering why hospital patients go to other states for their care, while not giving ourselves credit for the outstanding job we have done.

I think it is important for us to recognize that when we talk about the DRG system it is simply a mechanism to fulfill the

requirements of Chapter 83 -- a law that says hospitals must be provided solvency for efficiently operated institutions, a law that gave the Rate Commission the authority to set all of the rates for all of the patients in our hospitals. The Department decided to use the DRG system as the basis for doing that.

I think it is important to point out -- to the extent that you want to measure the effectiveness of our system in New Jersey -- one of the most important measurements over the years. From 1976 to 1982, hospital costs in this State ranked 48th-lowest in the United States. This is the latest available data. We would be happy to provide the Committee with that data, with a book that defines exactly where New Jersey hospitals are in relation to the rest of the nation, and with considerable other information that might be of interest to you, should you call on us as a resource.

I do not think it is possible to go much below 48th in the nation; I do think, however, that we run great risks if we fail to recognize that there is often excessive zealousness to contain costs and provide reductions in hospital revenues, and that this would be enforced by parties to the extent of perhaps not enabling hospitals to provide necessary services to the seven-million people in the State of New Jersey.

Again, I want to emphasize that we cannot go much below 48th in this country. I believe that the system has certainly demonstrated cost-effectiveness. One of the greatest strengths of our collective system of Chapter 83 and DRGs is that it guarantees health care for all residents of the State of New Jersey, regardless of their ability to pay and regardless of their private or personal resources. We believe that is one of the most important ingredients in the system of health and hospital care in New Jersey, and one that has distinguished it from many other problems we read of on the national scene.

We are proud of that situation. Let me respond to the question, "Can the system be improved?". There is no doubt that the system can be improved. I do not imagine there is any system, to date, that could not be improved -- including the Federal one.

We have shared improvements of which we were aware with the Department over a period of time. The question of timeliness of activities has long been a serious problem, as has the question of prospectivity of payments. An equitable answer to the question of integrating the planning and rate-setting processes has not been proposed. The question of whether or not there should be an independent staff to support the rate-setting mechanism is another issue which, if this Committee is going to look into issues regarding the future mechanism, I would hope to be one of them. One of the most important--

ASSEMBLYMAN OTLOWSKI: (interrupting) Those suggestions are in your written testimony, is that correct?

MR. SCIBETTA: Those specific suggestions are not, but we will document and send them to you.

ASSEMBLYMAN OTLOWSKI: Will you do me a favor? Will you make those specific suggestions -- the ones you just ticked off -- available to us in writing? I think they are very important -- and important to the Committee. Will you do that?

MR. SCIBETTA: Thank you, Mr. Chairman. We will look forward to doing that, along with, perhaps, the entire list that we have shared with the Department. As far as the waiver is concerned, we are on the record as supporting it. Chapter 83 guarantees financial solvency for hospitals, and the waiver was very much a part of the process of implementing that. We have been fortunate. There could be a maldistribution problem of about $100 million, in our estimate. This would be a serious problem the State would have to resolve, should we not have the same mechanism in effect -- that Medicare-Medicaid patients would not participate in our system, as they currently do.

There are steps that can be taken to deal with maldistribution. Hospital rates for current payers could be adjusted by the Rate Setting Commission, which would, in effect, move funds to hospitals that experience a shortfall. In summation, the continued implementation of the requirements of our existing law, Chapter 83, would be required to be exercised. Another alternative would be to create a pool of funds to be used for uncompensated care, from State and/or county funding.

In addition, we have been in support of the Medically Needy Program.

ASSEMBLYMAN OTLOWSKI: (interrupting) Excuse me for just a moment, please. Assemblyman Haytaian?

ASSEMBLYMAN HAYTAIAN: County funding is an alternative I hope we will not look at. It goes right to the root of the counties' problems in the past. They have had these problems, because their ability to provide funds for indigent care came directly from the homeowners who lived in those counties. I think that would be an alternative we would not want to consider.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, that is a very dirty word here. (laughter) Assemblyman Cuprowski, would you like to comment?

ASSEMBLYMAN CUPROWSKI: No, that's all right.

ASSEMBLYMAN OTLOWSKI: I am glad you brought that out, because it is not the first time we have heard this. As a matter of fact, that in itself is a frightening thought, and is something we want to avoid at all costs.

ASSEMBLYMAN VISOTCKY: Are you talking about this? (reads from copy of witness's printed testimony) "Another alternative is to create a pool of funds to be used for uncompensated care with State and/or county funding." Will you elaborate on that a little?

MR. SCIBETTA: I recognize that promoting county funding for this purpose is a historical dream that, to begin with, should never have come true.

ASSEMBLYMAN VISOTCKY: Okay, scratch county funding, and elaborate on it otherwise.

MR. SCIBETTA: Other than county funding? A pool from sources of funds that are currently the responsibility of the State to determine their whereabouts for the purpose of taking care of the poor and the elderly.

ASSEMBLYMAN OTLOWSKI: You're talking general revenue -- raising it through a general-revenue source?

MR. SCIBETTA: That is certainly one alternative that would have to be explored, because we are talking about a sizable sum of

money for the care of both the poor and the elderly, which are two different groups. I would like to point out--

ASSEMBLYMAN OTLOWSKI: (interrupting) Before you do that, let me ask this, because it has been bugging everyone on the Committee. Everyone has talked to you this morning, but no one has been able to pinpoint the answer to the question that has been asked repeatedly: How much money are we talking about?

At one time we heard $50 million; another time we heard a figure of $90 million.

ASSEMBLYMAN VISOTCKY: He said he's got $100 million. (referring to Mr. Scibetta)

ASSEMBLYMAN OTLOWSKI: You've got $100 million?

ASSEMBLYMAN VISOTCKY: Yes.

ASSEMBLYMAN OTLOWSKI: (to Mr. Scibetta) Are you saying $100 million?

MR. SCIBETTA: Let me give you the basis for our estimate of that figure, and, again, we are dealing with a $3.4-billion industry. These really are estimates but, in my judgment, they are pretty close. We are talking about an uncompensated-care pool of approximately $250 million. Forty-percent of that total is represented by those payers who fall under the aegis of the waiver -- Medicare-Medicaid. That leaves us with a figure of about $100 million.

How that is met, or redistributed, is the issue. We are dealing with a re-maldistribution problem, at that point, of some $100 million, in our judgment. It might be $90 million; it might be $125 million. It is, however, a pretty close estimate.

ASSEMBLYMAN OTLOWSKI: All right. I think you have helped clear up that point. Do you want to go on to what you said you wanted to mention? I am sorry that I distracted you; I hope you haven't forgotten what you wanted to say.

MR. SCIBETTA: I have not, Mr. Chairman. The point that I want to make is that the question of indigent or uncompensated care is not one that is germane to urban centers alone. It is germane to any of those areas in which poor people live, and poor people live in areas that are far from urbanized. Some live in areas that are very rural. Some live in our most southern, rural areas.

ASSEMBLYMAN OTLOWSKI: And some live in the suburbs. They can't be excluded from living in the suburbs.

MR. SCIBETTA: That is correct. According to our studies, that is exactly the case. The same is true with regard to Medicare. The waiver is germane to New Jersey because of its high population of the elderly, a fast-growing population that our hospitals take care of. They are all over the State. Forty-percent of our hospital patients are Medicare patients. The figure is higher than that in some of our hospitals, as high as 73-percent.

That is an important figure. The impact of Medicare patients, again, is not germane only to rural, urban, or suburban hospitals. It covers the extent and magnitude of our ability to deliver care throughout the entire State to the entire Medicare population. We think it is extremely important to continue to serve with the same high quality and accessibilty that we have in the past.

Let me summarize. First, the question is no longer just one of cost containment. I hope this Committee and others will continue to take a great deal of opportunity to talk about the hospital system and the responsibility for it, and will begin to concern themselves, as must the hospitals, with providing care to seven-million people in this State. We must provide top-flight hospital services, equipment, facilities, and so forth, or we cannot realistically expect people to stay in New Jersey. The cost of caring for them in the bordering states is higher. It does not make any sense to pretend we are going to reduce hospital costs effectively by closing 30 beds, when there is no one there to take care of those 30 beds anyway.

I hope that, in our zealousness to concern ourselves with the future of the hospital system, we begin to talk more of how we are going to be able to deliver services in the future. We have been preoccupied, since at least 1971, with how we are going to maintain and contain costs. Our costs have demonstrated that since 1976 -- with and without DRGs, with and without regulation -- we have had the 48th-lowest-rising health-care costs in the country. That is an incentive for everyone throughout New Jersey and the rest of the nation to take heed of, and for us to take pride in.

With that summary statement, Mr. Chairman and members of the Committee, I want to say, on behalf of the industry, how much we appreciate your taking the time to discuss what we consider one of the most important issues facing the people of New Jersey today.

I want my concern on the record that we do not have an alternate system available. You cannot tinker with a $3-billion industry, seven-million people who are on health care, and 107 hospitals on December 31 if you do not know for sure what is going to happen the next day. We are prepared, ready, and able to review our approaches -- both short- and long-range. I only hope that we are a sophisticated-enough State to deal with this kind of a problem up front -- and I am referring to all of the parties involved, since we were all involved in Chapter 83 and the implementation of the DRG program.

ASSEMBLYMAN OTLOWSKI: Thank you very much. You have been very helpful. Assemblyman Visotcky?

ASSEMBLYMAN VISOTCKY: Then you disagree with some of the testimony that we heard earlier about hospitals in certain areas that were not in favor of the waiver? They would, naturally, get an increase in funds for their Medicare patients, as opposed to it being distributed throughout the State.

MR. SCIBETTA: We have supported the waiver right along, but I want to say, on their behalf -- and I believe we have an understanding with the Department of Health, as well as with others involved at the State level -- that there could be a significant variance with regard to the care of the elderly and the indigent. It is absolutely essential for us to make certain we protect the service to those people, and the reimbursement to those hospitals which have an abundance of elderly patients, perhaps even more than the average 40-percent.

We can do that. We are committed, along with our members who are concerned about this issue of the waiver, to work closely with them. We have made that very clear, and I believe that we have a commitment from the State to do the same. If there is a specific problem -- not only with indigent care but also with elderly care -- I hope we may take the opportunity to come back to this Committee and share with it some of our proposals for dealing with that problem.

There are going to be built-in inequities in any system. We don't know that this is an inequity yet, but we want to make certain that we track it and, if we define it as such, deal with it head-on.

ASSEMBLYMAN VISOTCKY: Yes. I realize what we are talking about. We had testimony before, and I can appreciate Assemblyman Haines speaking about Burlington and Ocean Counties, which he represents and which have a large population of elderly people. Under Medicare, they would be compensated much more. What we are doing with the Hospital Association is to say-- I have heard rumors that say they are going to get 1.5 percent of their profit and distribute it up north. You know, I don't think we are divided into north and south. I think of us as the State of New Jersey. We should think of our State as a whole, not in terms of regionalization, where one particular region is opposed to the other.

It amazes me to see this. Suppose a hospital in a particular region does not have the type of facility for a particular operation -- let's say, St Joe's in Patterson for heart surgery. The people from that region probably wouldn't go to Deborah; most likely, they would go to St. Joe's. The same principle applies to people from South Jersey. What if a person who needs an operation happens to be indigent? Where would that be reflected, in terms of cost care? Would it be reflected in the South Jersey area where the person comes from, or would it be reflected in North Jersey because the hospital happens to be there? It sounds like a silly question.

MR SCIBETTA: I am sure it is not a silly question, but I am not sure I fully understand what your question is. Are you asking, if we did not have the waiver what would happen--

ASSEMBLYMAN VISOTCKY: (interrupting) Right.

MR. SCIBETTA: (continuing) --to care that is currently being provided to indigent patients?

ASSEMBLYMAN VISOTCKY: Yes. When the facility is not available in this group of hospitals that will be getting the extra money under the Medicare program.

MR. SCIBETTA: Under the Medicare program? If we did not have the waiver, in my judgment, what would have to happen is this law,

Chapter 83, would be required to be implemented in the way it was passed, because it was passed before we had the waiver. That would mean, in my judgment, that without a revision or alteration we would implement the law that would provide for an assessment of each hospital's required revenues; whatever Medicare pays to certain hospitals would have to be considered in the calculation of the total revenues of those hospitals -- if they paid more or less. If they paid less to certain hospitals, the other payers would pay more. For the sake of balance, it could be an even reimbursement system. It depends on how it is implemented. In my judgment, that is exactly what the law was when it was initially designed.

ASSEMBLYMAN FELICE: Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Yes, Assemblyman Felice?

ASSEMBLYMAN FELICE: Just one valid point that I always like to reiterate, and it is worth repeating. I think the people of New Jersey and the commissions involved have to understand that you said the amount of elderly people in New Jersey is second, in the United States, only to Florida.

When you think about it, that is a big factor which involves Medicare and other programs which we have been talking about. Second only to Florida in the United States. That is something we have to consider in all of these programs, Mr. Chairman. I would like to reiterate what he said about the large amount of elderly people who populate this State and who have to be cared for.

MR. SCIBETTA: Thank you, Mr. Felice. One final thought, Mr. Chairman and members of the Committee: We found ourselves, a year and a half ago, an industry among 11 states in this country that had bigger problems than we, in terms of modern equipment such as CAT scanners. We were almost at the bottom of the list.

The hospitals and the Hospital Association, collectively and along with some of our colleagues in the medical profession, made this a point and said, "We are not going to tolerate this anymore."

Fortunately, government moved. In our zealousness for cost containment, the historical argument, I hope we don't find ourselves in that situation once again. We have too old and too large

a population to provide second-class care. I don't think you want that. I know our hospitals do not.

ASSEMBLYMAN OTLOWSKI: Excuse me, please. (confers with Chris Simon, who has returned to the Chamber, then disseminates copies of a document to Committee members) Incidentally, and this is for the Committee's attention: The document I just passed on to you is the letter everyone was talking about. It is, for the moment, to stay within the Committee. I am asking every Committee member to withhold the letter from any kind of release or discussion for the moment. It is purely for the perusal of the Committee members. Would you honor that please? (affirmative response from Committee members)

Mr. Scibetta, I am sorry. Do you want to further develop the point you were just making?

MR. SCIBETTA: Mr. Chairman, the only comment I would like to make before I depart is this: We have a major responsibility to our seven-million residents, and we need your help to make certain we are not in the position of being last on the list in the State of New Jersey with approved equipment, resources, facilities, and people to deliver health care to our residents. I know that is your interest, as well as ours.

ASSEMBLYMAN OTLOWSKI: I want to say this, because you and Assemblyman Visotcky touched upon something which I think we have to repeat. We are not here as a regional committee; we are here as an Assembly Committee representing the people of New Jersey. This is a State problem, as far as we are concerned. Not only that, but we are talking about -- and excuse me for using economic terms -- a big industry. We are talking about a $3-billion industry, as you indicated.

Moreover, we are talking about the health care and prevention of disease of 7.5-million people. This is the way we, as a Committee, look at this. These hearings are not held to please anyone. They are not held to butter up any special-interest group, any individual, anyone representing the Administration, or any member of this Committee. They are being held to enable us to learn some of the things that we have learned today. As a matter of fact, some of the

basic recommendations that have been made today are, I believe, of tremendous importance to the entire system.

I wanted to stress that because of the way I have been besieged over the last few days. Everyone had their own special way of solving this. I was not kidding when I told the children that we have all kinds of experts here, as well as those who are not so expert. Not that I have any special regard for the experts. Sometimes they merely confound and confuse you; or, to put it more simply, they sometimes screw up a simple approach. I am not catering to experts, but I think that, out of all of this, we are probably going to get something that the State, as you said, is entitled to.

Not only that, but we are not here to impede any kind of appeal or machinery that is in process to save what can be saved for New Jersey. I just want that known. This is not an instant hearing -- one where we will sit down instantly, hear everyone, then walk out and say, "Well, we have conducted the hearing. Hooray! It is all over." This hearing, of course, is only the beginning. I just want everyone to understand that, because I am going to adjourn soon. Some people are not going to be heard, and they are going to feel that I am a harsh, tyrannical, dictatorial person.

ASSEMBLYMAN VISOTCKY: (interrupting) You are. (laughter)

ASSEMBLYMAN OTLOWSKI: Notwithstanding Assemblyman Visotcky, I am not.

ASSEMBLYMAN VISOTCKY: The Committee's agreeing. (more laughter)

ASSEMBLYMAN OTLOWSKI: I just wanted that known. I hope we can cut off at this point. Again, I want to express my appreciation to those who testified, and to those who came but did not testify. That's it for this hearing. The Chair will announce the next date, and our staff members will be in touch with everyone for the next public hearing. Thank you very much. This hearing is now adjourned.

(HEARING CONCLUDED)

APPENDIX

STATEMENT OF
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

STATE OF NEW JERSEY
ASSEMBLY CORRECTIONS, HEALTH & HUMAN SERVICES COMMITTEE

November 30, 1984

Good morning. I am J. Joseph Frankel, Vice President, Government Relations, of The Prudential Insurance Company of America. Joining me is Marsha Rosenthal, Director, Health Policy Coordination, also of The Prudential. I am here to repeat our support for the work of the New Jersey Legislature in developing and passing legislation that established the New Jersey State Hospital Rate-Setting Program. We also continue to support the diagnosis related group (or DRG) approach established by the Department of Health, and we strongly support continuation of the federal waiver for this New Jersey program.

Since the implementation of the DRG program, The Prudential has worked closely with the Department of Health and with the New Jersey Hospital Rate-Setting Commission to insure the smooth transition from the old hospital payment system to the new DRG hospital payment system. We commend both the Department and the Commission for their sincere efforts to put in place a complex new program that has required hospitals, payors, and the public to change their way of thinking about hospitals. This kind of change is always difficult, but, with our work in 50 states around the

country, we have found that the only way to contain hospital costs is for this kind of change in thinking to occur. By phasing-in the DRG system in the first few years, the State gave the hospitals and the public time to adjust to these changes.

In our estimation, the DRG program in New Jersey is fully implemented as a working hospital payment system. We believe it has been successful in several ways:

First, DRG approach gives hospitals and doctors a management tool they did not have before. All of the State's hospital administrators and their physician staffs are talking to each other in a more constructive way, sharing decision making about costs and lengths of stay. We believe the DRG system gives hospitals an incentive to treat the patient more efficiently, and that this is an advantage to everyone, particularly the patient.

Second, several inner-city hospitals, which had been on the brink of bankruptcy in 1979, now operate in the black. Because the hospital rate-setting law requires that hospitals be made whole for their bad debts, the DRG system establishes that all payors will contribute to

covering the hospitals' bad debts. These hospitals can continue to serve the poor who would have no other access to care.

Finally, the law requires that all patients be charged on an equitable basis, regardless of who provides their coverage. This results in greater private sector competition between Blue Cross, insurance companies, health maintenance organizations, and employer and union health benefits plans. We believe this competition will be to the benefit of all New Jersey citizens.

There have been some difficulties in the implementation of the DRG program over the last few years. We have addressed our concern about these difficulties to the Department of Health, and to the Rate-Setting Commission. In general, the problems we observe are not in the working of the system itself, but in the monitoring and evaluation of the results of the DRG's, and in keeping the system on track as a cost containment program. We have two main suggestions:

1. The State should develop a clear, explicit monitoring and evaluation process for the DRG program. A limited set of key figures

that will show whether or not the DRG system is working to control costs should be compiled and released to the public on a regular basis. (This would be much like the monthly release of CPI information from the federal government.) If figures were released once every six months, it would do a great deal to clear up the rumors and misinformation about the DRG program.

2. We believe the time has come for the Department of Health and the State's hospitals to agree on the next step in cost containment under the DRG program. Last summer, the Department of Health released new regulations intended to create greater cost containment under the program. While there may have been problems with these regulations as drafted, we believe that the hospitals and the Department of Health, working together, should agree on some further steps. We would be happy to assist in any way, if that be desirable.

We believe the continuation of the federal Medicare/Medicaid waiver is key to the DRG program. Without this waiver, the two federal health programs cannot participate in the New Jersey Rate-Setting program, and will not participate

as equitable payors. This means that any patient not covered by Medicare or Medicaid will be facing additional costs added to the hospital bill to make up for the Medicare/Medicaid shortfall. It will be more difficult for hospitals in the State to respond to the cost containment incentives in the DRG program if they are facing two separate payment programs, one for private sector patients and one for public sector patients. We believe the State has done a credible job in their application for the Medicare/Medicaid waiver, and we hope that the federal Department of Health & Human Services will respond soon in granting the new waiver.

We believe New Jersey has been a pioneer in establishing a State program that has equity in both the private sector and the public sector, and we trust this State Legislature will remain committed to that principle.

JJF:fl

STATEMENT OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

WITH RESPECT TO

THE NEW JERSEY DRG REIMBURSEMENT SYSTEM

AND THE RELATED MEDICARE WAIVER

November 30, 1984

My name is Edwin Soeffing and I am Counsel for the Health Insurance Association of America (hereinafter referred to as "HIAA"). The HIAA is a trade association representing more than 300 health insurance companies writing private commercial health insurance throughout the United States. According to our figures, more than 100 HIAA member companies are currently licensed to do accident and health insurance business in the State of New Jersey. And, according to HIAA's 1982 annual survey, private health insurance carriers paid over $893,000,000 in accident and health insurance benefits to approximately 2,500,000 private insureds in New Jersey in that year.

I am pleased to have this opportunity to appear before you today, especially since HIAA has taken a very active role in supporting the enactment of Senate Bill 446 (Chapter 83, PL 1978). Since that law established the DRG Reimbursement System, HIAA has continued to work with State Department of Health personnel to try to help the System work.

As part of HIAA's continuing support for the New Jersey System, HIAA recently contacted HHS Secretary Heckler on behalf of the waiver application submitted by the State of New Jersey. In his letter to the Secretary, Mr. James L. Moorefield, President of the HIAA, referred to "New Jersey, as one of the four states which is currently implementing an all payor prospective hospital payment system." He further noted that New Jersey has helped achieve "significant savings for both Medicare and the Private Sector during the first four years of the program."

The New Jersey Department of Health agreed. In its recent waiver application, the New Jersey Department of Health estimated that perhaps $220,000,000 in savings was achieved during the first three years of the waiver. It further estimates that $126,000,000 is expected to be saved during the three-year time period for which the new waiver is being requested.

HIAA is disappointed therefore by the November 7, 1984 letter from HHS indicating that New Jersey's present application for a continued waiver is "not approvable as submitted". We hope HHS can be persuaded to change this position through the current negotiations with the State.

HIAA says this because it believes the present DRG System is beneficial for the State of New Jersey. As one of the original all payor programs, this System established a uniform payment system for all hospitals and payors that clearly defines the hospital's full financial requirements. This served to

establish a basis of payment recognized by all payors, which, as a result, helps to eliminate cost shifting.

As many of you know, cost shifting is the result of the perverse incentives created by fragmented reimbursement programs implemented unilaterally by various payors. When cost shifting occurs, it is usually because some payors are able to negotiate exclusions of payment for such things as bad debts, charity care, working capital, and research and education costs. Consequently, payors, which include self-paying and insured patients, whose rates are not subject to contractual negotiation, are required to pay for more than their fair share of hospital financial requirements. They are also required to unfairly carry the financial burden of unmet requirements produced by negotiated payment shortfalls.

Perhaps even more importantly, a fragmented reimbursement system does not create incentives for hospital management to implement cost containment programs that produce efficient and quality health care for all patients. In the absence of a system designed along the lines of the present DRG System, the incentive remains for hospitals to continue to shift costs rather than to institute necessary changes in practice patterns.

In New Jersey, we have seen the favorable impact of the DRG system. Hospital management appears to be working with their clinical staffs to deliver health care more effectively and more efficiently. This system lends itself to the production of data which can be used by hospitals to evaluate the

effectiveness of their delivery of care, so that they can make modifications where necessary. Thus, the creation of incentives to develop alternative forms of care, which is a major change in the delivery of care, is one of the benefits of the DRG System.

The all payor approach also provides direct benefits to New Jersey hospitals by recognizing that hospital bad debt and charity care is one of the financial elements for reimbursement, so that all payors contribute to covering these costs. According to the State Department of Health, approximately $200,000,000 more was available to hospitals in New Jersey to cover the cost of uncompensated care last year. Inner city hospitals are among the beneficiaries of this program which has enabled many financially distressed hospitals to continue to provide improved health care services for the poor and the indigent.

Finally, the New Jersey DRG Reimbursement System instituted a mandatory program for hospital utilization review for all patients. This guarantees that an effective quality assurance process is available for all admissions. Such a process ensures the necessity of these admissions and appropriateness of the length of stay. It also gives the System the capability of generating data reports so that the State can monitor the effectiveness of the System and gain information on areas for improvement.

Since the DRG Reimbursement System affords many advantages and benefits, the HIAA sees the overall impact of the program as definitely favorable. However,

problems do exist, and some of these jeopardize the continuation of the Federal Medicare waiver related to the System. This was made crystal clear, of course, by the November 7, 1984 HHS letter to Governor Kean (signed by Ms. Carolyne K. Davis, Ph.D., Administrator). Because that letter sets out its own concerns in detail, we will not comment further on it here.

Suffice it to say, however, that HIAA is concerned, for example, about the source of the $28,000,000 overpayment projection for the first year contained in the waiver application submitted by the New Jersey Department of Health. We are also concerned with a substantial weakness of the present System, namely, the lack of data presently available to interested parties despite the fact that the System currently has the capability to generate this information. HIAA believes it is imperative for the Department of Health to identify and to produce the types of data reports which will be beneficial in evaluating the System's strengths and weaknesses.

HIAA also believes the present utilization review system can be improved. Current estimates of the New Jersey Department of Health and the New Jersey Hospital Association are that approximately $10,000,000 is currently being spent by all payors for utilization review. Previously, regulatory recommendations had been made to strengthen the utilization review process. Unfortunately, these recommendations were withdrawn by the Department of Health prior to their actual review by the Health Care Administration Board. HIAA suggests, therefore, that the Department reconsider its position and give further consideration to improvement of the current utilization review system.

In conclusion, HIAA suggests that the Department of Health establish a data reporting system that allows the Department's staff, the Rate Setting Commission, and other interested parties (such as this Committee), to accurately monitor and evaluate the DRG Reimbursement program. Aided by such data, further improvements to the System can be made which will help lighten the financial burdens of the hospitals, the payors, and the public.

I want to thank you for permitting me to make this presentation here today on behalf of the HIAA. We will be happy to answer any questions that you may have.

NJHA NEW JERSEY HOSPITAL ASSOCIATION

at the Center for Health Affairs (609) 452 9280

746-760 Alexander Road
CN-1
Princeton, New Jersey 08540-0706

Louis P. Scibetta FACHA
President

TESTIMONY OF

LOUIS P. SCIBETTA, F.A.C.H.A.
PRESIDENT, NEW JERSEY HOSPITAL ASSOCIATION

ON THE DIAGNOSIS RELATED GROUP SYSTEM
AND MEDICARE WAIVER FROM THE PROSPECTIVE PAYMENT SYSTEM

BEFORE THE
ASSEMBLY CORRECTIONS, HEALTH & HUMAN SERVICES COMMITTEE

NOVEMBER 30, 1984

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MEMBERS OF THE COMMITTEE, I AM LOUIS P. SCIBETTA, PRESIDENT OF THE NEW JERSEY HOSPITAL ASSOCIATION, REPRESENTING 106 NEW JERSEY HOSPITALS.

I WANT TO THANK YOU FOR ALLOWING ME THIS OPPORTUNITY TO TESTIFY ON THE EFFECTIVENESS OF NEW JERSEY'S DIAGNOSIS RELATED GROUP METHOD OF REIMBURSEMENT TO OUR ACUTE CARE HOSPITALS AND THE CONCERNS THAT WE HAVE, SHOULD THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION DECIDE NOT TO GRANT THE STATE A WAIVER FROM THE NATIONAL PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE .

ONE OF THE PROBLEMS WITH DEALING WITH THIS MOST COMPLEX ISSUE IS THE NEED TO UNDERSTAND THAT THE HEALTH CARE REIMBURSEMENT SYSTEM IS MORE THAN JUST THE DRG SYSTEM. DRGS ARE MERELY WAYS OF PAYING FOR OUR SERVICES. THEY ARE NOT NECESSARILY THE DRIVING FORCE BEHIND DELIVERY OF HEALTH CARE. THE DRG SYSTEM, COMBINED WITH THE LAW PASSED IN 1978, KNOWN AS CHAPTER 83, AFFECTS NEW JERSEY'S HOSPITALS MUCH MORE DRAMATICALLY. IT IS IMPOSSIBLE TO DISCUSS THE DRG SYSTEM WITHOUT ALSO DISCUSSING THE RAMIFICATIONS OF CHAPTER 83.

First, let me deal with the effects of DRGs and Chapter 83 which was intended to achieve three goals: (1) contain rising costs, (2) ensure accessibility of care for the poor, and (3) ensure solvency for effective and efficient hospitals.

Certainly, the system has helped to contain costs.

Our industry has long been concerned about the rising cost of care and as early as 1969 there was a form of rate-setting and voluntary participation by hospitals in the state. As a result of this concern, hospital rates have risen at a much slower rate in New Jersey, compared to the rest of the nation. For the period from 1976 to 1982, New Jersey ranked 48th lowest in the United States in percent of increase in both total expenses and total net revenue per adjusted admission. The phase-in of the DRG system began in 1980, so there is no question that hospital rates have risen less rapidly in New Jersey over the years before and during the DRG system.

CHAPTER 83, ALONG WITH DRGs, HAS STIMULATED HOSPITALS TO EVALUATE CLOSELY THE SERVICES THEY PROVIDE AND TO USE ALTERNATIVES TO INPATIENT CARE, SUCH AS PRE-ADMISSION TESTING, OUTPATIENT TREATMENT, HOME HEALTH SERVICES, AND SAME-DAY SURGERY. THEY HAVE STREAMLINED THEIR APPROACHES IN DELIVERING INPATIENT CARE.

IN THE PAST, FOR EXAMPLE, A BATTERY OF TESTING MAY HAVE BEEN CONDUCTED TO DIAGNOSE AN ILLNESS. NOW, PROTOCOLS HAVE BEEN ESTABLISHED TO ELIMINATE UNNECESSARY TESTING. THE TESTING IS PERFORMED IN A SEQUENCE TO ENABLE THE PHYSICIAN TO DECIDE IF FUTURE OR ADDITIONAL TESTS ARE TRULY NECESSARY TO THE FINAL DIAGNOSIS. THIS APPROACH ELIMINATES THE EXPENSE OF NEEDLESS TESTING AND OFTEN REDUCES THE PATIENT'S LENGTH OF STAY.

IT IS IN THE COLLECTIVE INTEREST OF THE HOSPITALS AND PHYSICIANS TO MAKE SURE THAT COSTS ARE CUT AND THAT PATIENT CARE CONTINUES AT ITS HIGH STANDARDS. THE DRG SYSTEM, AT THE VERY LEAST, HAS MADE PHYSICIANS VERY MUCH AWARE OF HOW THEY AND THEIR COLLEAGUES ARE PRACTICING MEDICINE AND MOREOVER, THEY ARE NOW MUCH MORE CONSCIOUS OF THE COST OF HOW THEY PRACTICE MEDICINE. ANOTHER ACTION, DIRECTLY ATTRIBUTABLE TO DRGs, IS THE MORE ACTIVE INVOLVEMENT BY PHYSICIANS IN HOSPITAL PLANNING AND COST CONTAINMENT EFFORTS WHILE HELPING TO ASSURE THAT PATIENTS RECEIVE QUALITY CARE.

HOSPITAL MANAGEMENT CAN ALSO TAKE CREDIT FOR THESE SAVINGS THROUGH AGGRESSIVE COST CUTTING CAMPAIGNS. THESE ACTIONS INCLUDE:. GROUP PURCHASING, WHICH HAS SAVED HOSPITALS LITERALLY MILLIONS, GROUP INSURANCE, COMPUTERIZATION, STRICTER BUDGETING, EXCELLENT PLANNING, RESTRUCTURING OF LONG TERM DEBT, INCREASED ENERGY EFFICIENCIES, A CLOSER LOOK AT STAFFING PATTERNS, EMPLOYE INCENTIVE PROGRAMS THAT REWARD OUR WORKERS WHEN THEY FIND WAYS TO DECREASE WASTE, AND MANY OTHERS.

CHAPTER 83 HAS ALSO MET ITS SECOND GOAL OF ENSURING ACCESSIBILITY OF CARE FOR THOSE WHO CANNOT PAY FOR IT. IN OUR STATE, THOSE WHO CANNOT PAY FOR THE COST OF THEIR CARE HAVE THE ACCESS TO QUALITY CARE JUST AS THOSE WHO HAVE INSURANCE OR ARE SELF-PAY PATIENTS. WE CAN BE JUSTIFIABLY PROUD OF OUR SYSTEM.

WHEN CHAPTER 83 WAS PASSED, IT WAS THE CONCERN OF THE LEGISLATORS THAT HOSPITALS BE REIMBURSED FOR BAD DEBTS AND INDIGENT CARE PLUS OTHER FINANCIAL ELEMENTS NECESSARY TO OPERATE A HOSPITAL. CHAPTER 83 GUARANTEES FINANCIAL SOLVENCY FOR EFFECTIVELY AND EFFICIENTLY RUN HOSPITALS.

THIS LEGISLATION ENABLED THE STATE TO MEET ITS OBLIGATION TO PROVIDE HEALTH CARE TO THE POOR BY ASSURING HOSPITALS THAT THE COST OF THAT CARE WOULD BE FULLY PAID FOR.

LET US NOW LOOK AT THE POTENTIAL PROBLEMS CAUSED BY THE LACK OF A WAIVER.

IN ORDER FOR MEDICARE AND MEDICAID TO PARTICIPATE IN CHAPTER 83, IT WAS NECESSARY TO OBTAIN A WAIVER FROM THE FEDERAL GOVERNMENT. IT SHOULD BE UNDERSTOOD THAT A WAIVER MERELY PROVIDES THE CONVENIENCE OF DISTRIBUTING MEDICARE DOLLARS.

WITHOUT A NEW WAIVER IN 1985, THERE COULD BE A MALDISTRIBUTION OF ABOUT $100 MILLION -- A SERIOUS PROBLEM THAT THE STATE WOULD HAVE TO RESOLVE.

THERE ARE INDEED STEPS THAT CAN BE TAKEN TO DEAL WITH THE MALDISTRIBUTION OF FUNDS.

THE HOSPITAL RATE SETTING COMMISSION CAN ADJUST HOSPITAL RATES AND, IN EFFECT, MOVE FUNDS TO THOSE HOSPITALS WHICH WOULD EXPERIENCE A SHORTFALL IN CARING FOR THE POOR OR CARING FOR THE ELDERLY.

ANOTHER ALTERNATIVE IS TO CREATE A POOL OF FUNDS TO BE USED FOR UNCOMPENSATED CARE WITH STATE AND/OR COUNTY FUNDING.

IN ADDITION, THE MEDICALLY NEEDY PROGRAM MUST BE EXPANDED SO THAT WE CAN STRENGTHEN OUR ABILITY TO CARE FOR THE NEAR-POOR. DOING THIS WOULD ENABLE THE STATE TO TAKE ADVANTAGE OF FEDERAL MATCHING FUNDS TO OFFSET THE COST OF CARE.

IN ANY EVENT, I DO NOT BELIEVE THAT THE PEOPLE OF THE STATE OF NEW JERSEY SHOULD PERMIT A TWO-TIERED HEALTH CARE SYSTEM TO DEVELOP. THERE IS THE DANGER, IF WE LOSE THE WAIVER AND THE STATE NOT ASSUME THE RESPONSIBILITY FOR ADDITIONAL FUNDING OR DISTRIBUTION OF DOLLARS, THAT LESS FUNDS WOULD BE AVAILABLE TO SERVE THE HEALTH CARE NEEDS OF THE POOR AND THE ELDERLY. QUALITY OF CARE FOR BOTH THE LESS FORTUNATE AND THE ELDERLY MUST BE MAINTAINED.

THANK YOU FOR YOUR TIME AND YOUR ATTENTION TO THESE SERIOUS CONCERNS. I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.