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

before

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

"Review and discuss the recommendations of
the Governor's Commission on Health Care Costs"

November 14, 1990
Room 424
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey, Chairman
Senator Francis J. McManimon

ALSO PRESENT:

Eleanor H. Seel
Office of Legislative Services
Aide, Senate Institutions, Health and Welfare Committee

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Hearing Recorded and Transcibed by
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New Jersey State Legislature
SENATE INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE
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NOTICE OF A PUBLIC HEARING

The Senate Institutions, Health and Welfare Committee will hold a public hearing on **Wednesday, November 14, 1990 at 10:30 A.M. in Room 424 of the State House Annex, Trenton.**

The purpose of the public hearing is to review and discuss the recommendations of the Governor's Commission on Health Care Costs. The committee will hear testimony from health care providers, government officials, third party payers and consumers of health care.

The public may address comments and questions to Eleanor Seel, Committee Aide and persons wishing to testify should contact Sophia Love, secretary, at (609) 292-1646. Those persons presenting written testimony should provide 10 copies to the committee on the day of the hearing. The chairman may find it necessary to limit the number of witnesses and the time available to each witness at the hearing.

Issued 10/31/90

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SENATOR RICHARD J. CODEY (Chairman): Good morning. We'd like to start today's hearing. Would everyone please be seated and take any conversation outside?

The purpose of today's hearing is on the Governor's Commission on Health Care Cost Report. Our first witness this morning is Ms. Brenda Bacon, Chief of the Office of Management and Planning, and Chairperson on the report itself. Good morning, Ms. Bacon.

B R E N D A J. B A C O N: Good morning, Senator.

SENATOR CODEY: Go right ahead.

MS. BACON: Thank you.

Good morning, Mr. Chairman and members of the Committee. Today you will hear from many different perspectives the various stresses that have rendered our health care system critical. From this point forward, you and your fellow legislators will act as the trauma team in an effort to not only save this patient, but to restore him to good health. In this vital mission, you must call upon the various experts who can provide specialized advice, although this advice will be conflicting in some areas. As leaders of the trauma team, you must sort through the second and third opinions you will receive and decide the best course of treatment. The patient will not recover overnight; there are no miraculous cures. A long recuperation will be required. But whether the patient recovers, and to what extent, will depend on your treatment plan -- both your short-term and long-term intervention.

The previous treatment that the patient has received has been episodic, and it has suffered from long periods of neglect. It is now being kept alive by artificial and expensive means.

The course of treatment will be controversial because there is little to guide you, and the patient's illness is not localized but affects every part of his body.

Various experimental treatments are being tried on similar patients throughout the country -- but your patient is unique and, therefore, his course of treatment must be unique.

In April of this year, the Governor appointed a Commission to study this patient and to recommend to you a course of treatment. This advisory body presented its Report on October 1, just six weeks ago.

The Commission deliberated for five-and-one-half months. It received and reviewed hundreds of documents and heard testimony from over 60 individuals and groups.

The health care industry in this State is a more than $20 billion a year enterprise. That's a lot of money by anyone's calculation. There's a lot at stake. There are very strong opinions and a great deal of finger pointing regarding the causes of the unprecedented rises in health care costs in recent years.

The Commission did not attempt to apportion blame, because in many ways our system is at fault, not its individual components. But each of those components must work together to effect a rehabilitation. Throughout the Report are recommendations that some will argue are too painful for their part of the body -- that the prescribed treatment causes them too much sacrifice. They will suggest that you work on another part of the patient first and see if that makes the patient better, and if so, maybe you won't involve them. But the Commission firmly believes that comprehensive treatment is required.

The treatment plan prescribes strong medicine for five major parts of the system:

1) Regulatory Reform,
2) Reimbursement and Financing Reform,
3) Health Delivery Systems Reform,
4) Insurance Reform, and
5) Uncompensated Care Reform.

I'd like to review with you, briefly, the major symptoms that these parts of the system are experiencing and what the Commission prescribes to address these problems.

New Jersey has long been a leader in health care planning and cost containment. Our 1971 law preceded Federal regulation by several years. Many states -- and in fact, the Federal government -- took their lead from New Jersey. However, our innovations have long faded and we have spent our time for the past several years in addressing growing problems and new challenges by taking incremental, tentative, and technical baby steps, instead of the surefooted, bold and forward moving steps we took in the past.

We now have a regulatory system that allows new and expensive technology to sprout up willy-nilly, while we pretend to oversee a regionalized, nonduplicative approach. We have no up-to-date, comprehensive, and living document to anticipate the health care needs of our citizens and adequately plan to meet them. We approve multi-million dollar hospital construction projects that we must all pay for without adequate attention to whether we can afford them and when we can afford them. At no point in the system did we decide, as a community, that we could afford or vitally needed to spend over $1 billion in one 12-month period for bricks and mortar.

The Commission recommends several changes to effect a State Health Plan for New Jersey that will guide these costly decisions and recommendations; that a plan be developed and kept current through the input of all the affected parties; those who use services, those who provide services, and those who pay for the services.

This part of the Report contains 17 recommendations, including a one-year finger-in-the-dike for hospital projects exceeding $10 million, a review of the definition of a health care facility so that we don't have another regulatory fiasco

like the MRI situation, and the revitalization of local input into the decision-making process with Local Advisory Boards.

In the Reimbursement and Financing sections of the Report, recommendations address the reform of the Medicaid delivery system by using managed care as a method of better health care delivery and as an effective cost containment tool, and the expansion of eligibility to bring in Federal matching funds for costs we are now paying for through the Uncompensated Care Trust Fund.

Hospital reimbursement is one of the prime areas where New Jersey's health care system has fallen into disrepair. Hospitals and payers alike have complained long and vigorously about the lack of perspectivity and the complicated, bureaucratic, slow regulatory process, resulting in cash flow and solvency problems. Some hospitals are still waiting for final decisions on costs incurred five years ago. Payers are rightfully concerned about the 2000 rate appeals that were filed this year and the monthly changes in mark-ups on hospital charges. The Commission made recommendations that will allow the rate reimbursement system to operate as it was intended in its authorizing legislation -- the setting of one comprehensive, adequate, and fair perspective rate for each hospital, once a year.

One of the obvious stress points in the system is the cost of health insurance. While the entire Report aims at containing costs, like prohibiting balanced billing for Medicare clients, the Commission makes several recommendations that will directly help insurance be more affordable and available to those who most need it.

In the area of the Report that focuses on health care delivery systems, we attempted to address what one testifier, Sister Margaret Straney, referred to as a "sick care system" rather than a "health care system." Until and unless we start to put our money where our mouth is, namely on prevention and

early intervention, our available health care dollars will never catch up to the demand for them.

And, finally, the issue which has generated the most debate to date, although it represents only a few of the 92 recommendations in the Report: The Uncompensated Care Trust Fund supports a proud public policy here in New Jersey; access to acute health care services regardless of the ability to pay. It prevents patient dumping and ensures the financial viability of our hospitals. It is supported by a 19% tax on all hospital bills, which translates into a tax on all health insurance bills. It has risen from $283 million in 1982, to an estimated $800 million to $900 million starting just 45 days from today. I need not tell you that it will cross the $1 billion mark all too soon, since its average growth has been 17% per year. This tax currently adds an average of $1000 to every patient's bill.

To quote from the Report: "The Governor's Commission on Health Care Costs believes that New Jersey has four options with regard to addressing the issue of funding care for the close to one million uninsured, the majority of whom are working people, and 25% of whom are children:

1) "Provide no coverage and thereby deny health care services to one million New Jersey citizens. There would then be no need for a 19% hospital tax or a new broad-based financing mechanism.

2) "Mandate insurance coverage by all employers, and thereby eliminate the need for the 19% hospital tax or a broad-based financing mechanism.

3) "Continue the current 19% hospital bill tax.

4) "Eliminate the 19% hospital bill tax and establish a new broad-based financing mechanism coupled with a series of reforms to contain the growth of health care costs, develop low-cost insurance vehicles, subsidize insurance premiums for employees in the small business sector, and for individual

purchasers, provide a system of incentives to encourage the purchase of insurance coverage, and a safety net for the residual uninsured."

The Uncompensated Care Trust Fund reimburses hospitals for the costs of charity care and bad debt. The Uncompensated Care Trust Fund assures universal access to hospital care, but it has several weaknesses:

1) The Uncompensated Care Trust Fund is supported by a tax, which in turn drives up the cost of health insurance. By taxing those who purchase health insurance to pay for those who either cannot or choose not to purchase health insurance, it represents an unfair tax burden on certain New Jersey citizens and businesses.

2) The current Uncompensated Care Trust Fund puts New Jersey businesses at a disadvantage in competing with businesses in other states and in the world marketplace. The tax has a direct impact on the cost of doing business for New Jersey companies, that is not borne by their competitors. The uncontrolled growth of the Uncompensated Care Trust Fund tax limits the ability of New Jersey's business community to invest in research and development, employment growth, and wage and benefit growth.

3) The current Uncompensated Care Trust Fund tax drives up the cost of health care causing more citizens and employers to be unable to afford health insurance, thereby, increasing the ranks of the uninsured; more uninsured, more costs to the Fund, more tax on hospital bills.

4) The current Uncompensated Care Trust Fund pays for health care at its most expensive store -- the acute care hospital. It does not compensate for care that could be provided in community health care centers, or by expanding and encouraging a primary care network. An uninsured person cannot visit a physician in a low-cost community health setting for non-acute illness, such as a minor respiratory infection,

without means of payment, but can go to the hospital emergency room at a cost of perhaps three to four times the cost. Such financial incentives are counter to controlling health care costs. They are likewise counter to the tenets of preventive and primary health care. Uninsured persons are likely to delay a medical visit until an uncomplicated respiratory infection progresses into a more complicated illness such as bronchitis, or pneumonia, perhaps necessitating a hospital stay. What therefore, could have been a $30 visit, has the potential to turn into a hospital stay costing several thousands of dollars, with the bill being picked up by the same Uncompensated Care Trust Fund that is not allowed to pay for the $30 visit.

5) The primary method by which the costs of uncompensated care can be reduced is by increasing the availability and affordability of health care insurance. However, the current Uncompensated Care Trust Fund does the opposite on both accounts. The Fund does nothing to expand the availability of insurance for low- and middle-income working people. The Fund, in fact, make insurance more and more unaffordable with each increase in the tax on hospital bills. This tax cost Allied Signal, a company with over 5400 New Jersey employees, over $1.2 million last year. It cost PSE&G $1.4 million this year. It cost New Jersey Transit $948,000. It cost Teamsters Local No. 560 $771,000. It cost Wakefern Foods $1.1 million. I could go on and on.

Why then, you say, does the New Jersey Chamber of Commerce and the New Jersey Business and Industry Association object to the elimination of this tax? Why do these businesses wish to continue to pay this tax, which will go from 19% to over 25% in less than two months? Clearly they are best positioned to answer these questions. And, clearly, we understand that a large part of their membership are small employers who do not offer health insurance and, therefore, under the Commission's Plan would have to begin to shoulder

some of the costs for their uninsured employees. However, it should also be noted that many of New Jersey's small employers do offer health insurance -- some estimate that 40% do -- and that they are paying as we sit here today a 19% tax to cover the hospital care of the employees of their competitors.

You will hear from some today that we cannot fix the problem of the way we raise the money for uncompensated care or the way we spend the money, because people don't understand the problem. They know their health insurance costs have been going through the roof, but they don't know that the 19% hospital tax is one of the driving forces. Therefore, it is politically unpalatable to kill this tax in favor of a lower, more broad-based financing and incentive plan.

You will also hear that we need to audit the Fund to determine the demographics of the users of the Fund. Indeed, we do need better information on charity care versus bad debt, and on collections. The suspicion is that there are people of significant means who are walking around without health insurance and refusing to pay their hospital bills and that hospitals are not vigorously pursuing them. A more likely situation is that the majority of bad debt is from working people of middle income who cannot afford the substantial deductibles and copays that they must pay to supplement their coverage. Under our current system, one can only be classified as charity care if they show proof of income and assets when they are treated or soon thereafter. Lacking this documentation, they are automatically classified as bad debt. That is why one of our major inner city hospitals has only 1% of its uncompensated care costs classified as charity care and 99% as bad debt.

We do need to improve our reporting system. However, this enhanced information will not change the basic decisions that confront us: Are we going to continue to provide access to acute care regardless of the ability to pay, and if so, how

do we pay for this care? Are we going to continue to pour all of the dollars into hospital care or are we going to devote some portion of them to subsidizing the insurance costs of employees of small businesses? Are we going to spend some portion of the pot on early out-of-hospital intervention or just continue to pay for costly emergency room care for nonemergency situations? Are we going to begin to treat this patient, called our New Jersey health care system, or are we going to let the illness progress?

The Governor's Commission on Health Care Costs presented its analysis and recommendations for your consideration.

We do not claim to have the only answers, but to suggest that viable answers are urgently required. While our Report has become the lightning rod for the debate, it will, hopefully, also become the foundation upon which you can build.

As I stated in my opening remarks, you will hear from many different perspectives today. They will not all agree with the Commission's 92 recommendations. There are, however, many recommendations that do have widespread support, and that, hopefully, will form the basis upon which we can move forward; for -- I venture to say -- that no one here today, or anyone that you will hear from during the course of your deliberations, will tell you that the patient is not critically ill, and as each day passes, his condition worsens.

Thank you very much. I'd be happy to respond to any questions.

SENATOR CODEY: Thank you, Ms. Bacon. Any questions, Senators?

SENATOR McMANIMON: No.

SENATOR CODEY: No. Brenda if you could list your priorities after uncompensated care, what would they be?

MS. BACON: That's tough. I think that we have to approach the reform as a package. I think to make changes in

only one part of the system without addressing the others is probably not going to accomplish our goals. I think we've got to make the system -- in terms of the rate reimbursement for hospitals -- more understandable, more perspective, able to allow hospitals to plan appropriately and for payers to plan appropriately. I think we need to develop a State plan to say where we are going and how we are going to get there.

We need to look at our whole Medicaid system, not only the way we are providing services, but what we are paying for it, why we are paying for it, and of course insurance reform. I can't identify a list of priorities in the sense of, do this first, and then six months this, and then later on this. I think that the Legislature truly has to look at what package of reforms need to be put together in order to effect real change in the system.

SENATOR CODEY: Even though the Governor's Commission has issued its report, will they meet again?

MS. BACON: I hope to call the Commission together again for a meeting in December as an effort to kind of review where we are. Some of the recommendation of the Commission have been implemented, the things that did not require legislation. On the administrative end, we have moved forward on several fronts, and so I'd like to be able to call the Commission back together and give them an update, on where we are and of course, give you the opportunity to give them an update of where we are legislatively.

SENATOR CODEY: What about the problems with the hospital bill, in terms of; someone runs up a $3000 bill, turns out -- because of the system -- to be a $15,000 bill and the public doesn't understand it? Have we done anything yet in regards to that?

MS. BACON: The Department is holding discussions with the industry to talk about how to reform the patient bill. One of the problems of the patient bill is that hospitals have set

their rates in a different way -- it does not conform with how the DRG system and the revenue flows -- so that you have in many cases an understating of the costs involved in providing this treatment. That's what comes out on the bill and looks like a great disparity between that and the DRG rate. There are discussions that we hope will render sometime in early '92 -- a solution to those problems.

SENATOR CODEY: Okay. In regards to a bare-bones package which has been talked about, what would you recommend that it contain?

MS. BACON: I think it has to contain two major pieces. One is that it has to have a primary care outpatient preventive aspect to it, so that we encourage early diagnosis and treatment, out of hospital. I think it also has to have a limited acute care benefit, because limited acute care benefits, I think, are what most people require. And those two pieces of the package would have to be balanced. I think to have a bare-bones policy that only covers acute care, really does not address some of the things we feel need to be addressed with regard to preventive and outpatient care.

SENATOR CODEY: But you would be addressing the problem with uncompensated care with an insurance package that covered hospitalization?

MS. BACON: I don't understand. I'm sorry.

SENATOR CODEY: In other words, if you go much beyond the hospitalization part, that increases the cost, and it makes it unattractive. I thought the idea was to cover uncompensated care, the cost of the hospital stay, and have it so low in terms of pricing that it would be attractive to individuals and employers who do not provide health insurance -- would buy it for themselves.

MS. BACON: I think including preventive primary care aspect to a bare-bones policy would be a low-cost addition to that policy. The majority of the cost of a health insurance

policy -- of a bare-bones policy of that type -- would be in the acute care stay part of it rather than the once-a-year physical or some early diagnostic work.

SENATOR CODEY: Okay. Thank you very much and thank you for having seized the initiative in terms of the whole issue.

MS. BACON: Thank you.

SENATOR CODEY: Our next witness is Dr. Frances Dunston, Commissioner of Health. Dr. Dunston?

COMMISSIONER FRANCES J. DUNSTON: Good morning, Mr. Chairman, Senator Codey, and members of the Committee. I am Dr. Frances Dunston, Commissioner of Health. I am pleased to have the opportunity to discuss with you today the recommendations of the Governor's Commission on Health Care Costs.

As Commissioner of Health I am pleased with the progress that the Commission has made, not only in clearly defining the issues that must be addressed, but also in developing a blueprint for immediate and longer-term action. The Health Department is eager to forge ahead in those areas where immediate regulatory action can be taken, and to seek your guidance and work with you on those issues that require legislative consideration.

As you have probably heard by now, testimony from dozens of practitioners, heath care providers, public interest organizations, labor and business representatives, and citizens revealed a health care system in crisis. Our health care system, while technologically advanced, is unable to provide even a basic minimum standard of access to hundreds of thousand of New Jerseyans. And with up to a million of our State's residents excluded from any insurance plan, we find ourself in a terrible dilemma, whereby we pay more and more for the care for fewer of our fellow citizens.

Finally, the Commission learned that in recent years our system of hospital payment regulation has fallen short of its goals, while creating utter confusion for patients, and an administrative nightmare for hospitals and insurers alike. To address these concerns, the Commission has recommended increased emphasis on prevention and primary care for the uninsured; the development of an alternative method of financing uncompensated care; and the restructuring of the regulatory and planning apparatus that governs hospital payment. Let me discuss these concerns and review proposed solutions in somewhat greater detail.

As you all know, New Jersey is fortunate enough to have a way to pay for the care of the uninsured. The Uncompensated Care Trust Fund was originally created to ensure universal access to care for all New Jersey citizens, regardless of the ability to pay. The Trust Fund paid hospitals for care rendered to those who could not or would not pay, by adding a surcharge to the hospital bills of patients with insurance.

This, however, is not an insurance plan. Rather, it provides for access to hospitals, but not for access to primary and preventive care that can head off more costly hospitalization. Those who are unable to receive early, managed, preventive, and primary care often face more extensive and costly care later on. A system such as this, which focuses only on financing hospital care, has undesirable economic and human consequences. The economic consequences have lately received much public and media attention, so let me begin with those.

The Uncompensated Care Trust Fund has been growing at a rate of 17% annually with no end in sight. Currently financed by a tax on people's hospital bills totaling 17% to 19%, we expect it to require a 23% tax in the coming years. The cost of the Uncompensated Care Trust Fund, coupled with the

generally rapid rise in the price of medical services overall, led directly to dramatic increases in the amount businesses and individuals must spend to purchase health insurance. Those fortunate enough to be able to purchase coverage for their workers or themselves are today faced with double-digit annual premium increases, sometimes exceeding 30% or 40%.

This has a pernicious, and compounding effect. As the cost of benefits escalates, employers and individuals are forced to give up their health plans. This is not through any lack of civic duty nor desire to have someone else pay the freight for health care. Rather, it stems from the raw economic reality facing employers who can no longer foot the ever mounting bills of the growing uninsured population. And as businesses drop their coverage, they add new members to the ranks of the uninsured, whose care may someday need to be paid for by the Uncompensated Care Trust Fund. So the expenses of that Fund rise and must be spread over fewer insured New Jerseyans. The cost of the insurance then rises even faster, and more people become uninsured, and a spiral of increasing cost and declining access accelerates.

When we discuss the dollars and cents of health care finance, we must not lose sight of the human side of the issue. People without ready access to needed services suffer. It should come as no surprise that in a system that pays short shrift to prevention and primary care, the poor suffer disproportionately. The point is, we are seeing the effects of this crisis, of a structure that may allow tertiary care when a disease is far advanced, but which fails to offer preventive services which can increase the quality and length of their lives while saving taxpayers money. Those who are most vulnerable, pay the price.

The Commission also took a hard look at the problems with the system we have in controlling hospital costs, which remain the biggest piece of the health care cost pie -- some

40% of it. The regulatory apparatus that has been developed to simultaneously control costs, ensure universal access to care, and promote hospital financial solvency, was found to have deteriorated into a hodgepodge of hundreds of special after-the-fact adjustments. This was a far cry from its ideal of a simple perspective form of cost containment which would treat citizens, insurers, and hospitals fairly. We also realized that an effective means of planning the distribution of health services, both inside and outside the hospital, had to be developed.

Finally, it became clear that the expenses incurred by physicians also had to be addressed, especially when those expenses lead to over $120 million annually in "balanced billing" for our State's senior citizens. The responsibility of providing access to reasonable cost belongs to all health care providers, not just to one segment.

The Governor's Commission made specific recommendations to address its myriad concerns. This Report is not a theoretical document. It is a plan for action. While a review of all of the 92 recommendations would surely stretch the patience of this Committee, there are some that I would like to highlight:

To address the full range of needs of the uninsured in an economically viable fashion, the Commission recommended reform of the private insurance market and an alternative method for financing care for the uninsured. The Commission also realized that both sides of the cost and access equation must be confronted. It does no good to cut costs, if it only results in cutting more people out of the health care system. We concluded the answer to the problems of the Uncompensated Care Trust Fund appears to lie in its restructuring, and not in its elimination.

The goal is to create a private insurance that is more amenable to the needs of the small employer, 40% of whom

currently do not provide insurance to their workers. The Commission stressed the need to more fairly finance the care of the uninsured while changing this system from one based on a model of sickness -- that is the Uncompensated Care Trust Fund -- to one based on a model of wellness. Specifically, the Commission recommended that, rather than paying only for hospital uncompensated care, a fund should be established to finance and subsidize the purchase of insurance by individuals and small businesses. The Commission stressed the need to spread the costs of such a fund across as broad a base as possible, as well as to provide financial incentives to employers to insure their workers. A newly revitalized insurer of last resort, a publicly sponsored Blue Cross/Blue Shield, could take the lead in bringing affordable insurance products to the market. Eventually we would see a system where nearly everyone has insurance and where the costs of care are spread equitably, rather than heaped upon the shoulders of a few.

The Commission also discovered that the Federal government has not been doing its share in attacking the problems of the low-income uninsured. Tens of thousands of women and children could have Medicaid coverage extended to them rather than being forced to rely on the Uncompensated Care Trust Fund. Such an extension would bring in millions of dollars in matching Federal contributions. We need to move with deliberate speed in this area.

Along these lines, the Commission recommended the expansion of our current HealthStart system of enhanced prenatal and infant care services to include not only potential Medicaid eligibles, but all pregnant women and young children with household incomes up to 300% of poverty. In Medicaid and HealthStart, we have the opportunity to provide some of our most effective services, while reducing the amount of uncompensated care that New Jerseyans must pay through this tax on their hospital bills.

In the realm of cost containment, we saw how ineffective efforts to equitably regulate the hospital industry have become. Specific recommendations were made to streamline hospital rate setting and develop a fairer system which will be more cognizant of the needs of hospitals for timely payment, and of the need of insurers and consumers for predictable, and reasonable expenditures. The Commission also made a strong recommendation that the senior citizens of this State not be subjected to physician billing in excess of Medicare's approved charges.

I am pleased to be able to announce today that my Department is already moving ahead with recommendations to restructure the regulatory process. Just last week, the Health Care Administration Board approved for initial publication, the first in a series of proposed regulations designed to make our hospital payment system simpler, more current, more perspective, and more predictable. The proposed regulations would establish a single, final, but adequate hospital payment rate for each year, eliminating the monthly markup changes that currently occur. The regulations would also restructure the process by which hospitals appeal individual rate adjustments to prevent new backlogs, and change the method of paying hospital overhead costs as a first step towards a single, equitable, all-inclusive payment rate.

In February, I will return to the Health Care Administration Board with regulations proposed to: establish benchmarks by which hospital performance can be measured on an individual and statewide basis; further refine the hospital payment rates so that they may better reflect the true costs of the care rendered; reform the hospital bill to make it more comprehensible to the consumer; and also to rebundle physician services. The Department is also moving ahead with a protocol to audit the Uncompensated Care Trust Fund -- as has been

indicated -- as needed, and also the revision of our regulations governing formulation of the State health plan.

Perhaps the most important recommendations of the Commission, cited our need to refocus our attention away from hospital-based systems of acute care and include more of a focus on community-based care -- particularly preventive and primary care. People need to be able to have a readily available source of these services; a source that can provide care on a reasonably short notice in a managed fashion on an outpatient basis before expensive inpatient hospitalization is required. While this thrust was implicit in many of the recommendations, it also was explicit. Community health centers -- long neglected -- should be fostered and should play a greater role, especially with regards to our State's underserved and uninsured population.

Specific plans to encourage health professionals to practice in these settings also need to be developed. The Commission backed these goals with the clear recommendation that dollars now going for uncompensated care in hospital emergency rooms and clinics be gradually and carefully redirected to community-based services in the coming years. In February, the Department will be proposing specific regulations which will establish incentives to make community-based health centers the principal site for the delivery of preventive and primary care.

Our situation here in New Jersey is not unique. Every State in the Union is grappling with them in some way or another. Real relief will come when a national solution is formulated. The individual states can do something, but do not have the span or resources that a national solution would offer. But such a plan, unfortunately, is not in the offing. There is no sign of Federal action yet. There is no sign that a crisis is abating. We are forced to act, because no one else

is going to come to our rescue. To wait for some far-off national panacea would be a dereliction of our duty to the people of New Jersey.

The Governor's Commission on Health Care Costs has issued a blueprint for reform which, taken as a whole, will lead to a far better system of delivering and financing health care in New Jersey. Its implementation will force us to rethink many of our assumptions about what form we want this structure to take. It may even mean that we, for the first time, actually think about the system as a single structure. However any of us elect to view it, one thing is clear: If we do not act now, no one else will.

As a member of the Commission, and as Commissioner of Health, I look forward to working with the Senate and the Assembly on the task ahead. Together, we can make a difference.

Thank you very much.

SENATOR CODEY: Thank you, Doctor. Any questions, Senator?

SENATOR McMANIMON: No.

SENATOR CODEY: Doctor, you had mentioned about the audit. At what stage are you at regarding that?

COMMISSIONER DUNSTON: We have developed a protocol that will allow us to do the audit. We are refining that protocol. It does call for some adjustments in the way we look at the data that we have available to us, but we have begun to move forward on that issue.

SENATOR CODEY: Can you give me a ballpark date as to when that can be finished?

COMMISSIONER DUNSTON: I would say, by the-- In the first quarter of 1991, we should be able to complete that process.

SENATOR CODEY: Okay. In regards to the overlap between Human Services and Health in a lot of areas of health,

especially in the Medicaid program, is there something that can be done in that regard to make a more efficient system, maybe under one umbrella?

COMMISSIONER DUNSTON: Well, we had not entertained that concept, although we work daily to coordinate our efforts with other departments including the Department of Human Services, particularly in the area of Medicaid and other areas that impinge upon health matters. So we do work very hard to coordinate our efforts in that regard.

SENATOR CODEY: But do you think all of it should be in one department, as opposed to being spread out over two?

COMMISSIONER DUNSTON: I cannot, at this point, make any assumptions about that.

SENATOR CODEY: Okay. What are your thoughts in regards to hospitals in collection of bad debt? Are they doing a good job, because the amount of bad debt is up tremendously?

COMMISSIONER DUNSTON: We have some concerns about the way we account for bad debt, and part of the audit of the Uncompensated Care Trust Fund will allow us to distinguish that what is truly charity care from that which is bad debt. So the audit, we believe, will give us a better handle on that question.

SENATOR CODEY: You had mentioned about the cost of uncompensated care related to prenatal care.

COMMISSIONER DUNSTON: Yes.

SENATOR CODEY: You have some initiatives to hopefully reduce that?

COMMISSIONER DUNSTON: Well, the Report does include a reference to that issue particularly. And we have asserted that the way to look at that issue is to take the best advantages as possible of the Federal resources that could be made available to the State through Medicaid. The HealthStart program was built on that premise. It currently serves women

up to 100% of poverty, with an expanded package of services for prenatal care, and also for infants up to six years of age.

The Federal government now has expanded that eligibility to 133%, and we have the option to extend to 185% now, currently under the Federal provisions. We want to take full advantage of that, and have labeled this expansion of service "HealthStart Plus." We also want to extend to 300% of poverty by taking advantage of the Garden State Health Plan we also have available to us. So the idea is to use current resources to take full advantage of our health care system, not only that that is available through hospitals, but also through community-based resources.

SENATOR CODEY: Okay. Thank you very much, Doctor.

COMMISSIONER DUNSTON: Thank you.

SENATOR CODEY: Our next witness is Mr. Charles Marciante, President of New Jersey State AFL-CIO and Cochairman of the Governor's Commission on Health Care Costs.

C H A R L E S H. M A R C I A N T E: Mr. Chairman, I'd like to thank you for the opportunity of being able to come up today and testify before your Committee.

Our written testimony we will submit to you, as a submission that we made to the entire Legislature a few days ago, which spells out in detail the major problem which we perceive in health care delivery in the State; that is the funding mechanism that will be required to continue a health care program as we know it here in New Jersey.

The testimony is quite complete on an understanding of how the formula works and the ability of employers who already provide health insurance to realize a marked savings in their health care plans.

As you know, the vast majority of the employers who are supporting the entire New Jersey universal health care plan -- which is really what we're doing today -- are suffering the burden of being able to continue to afford that program. It

was stated quite clearly by the two previous speakers what those costs are today and what they will be into tomorrow and beyond.

Since the care Report was issued on October 1, with the various press conferences and so forth that followed, we held a legislative conference of our own organization, with over 800 people in attendance, and for three days discussed among other things the Report that was issued on October 1 and the difficulties that we saw as reported by the Commission, on the continuation of the health care plans. Many of those organizations of our State AFL-CIO are going to be faced with them in the future.

I recall, back in September of 1988, there was a grave concern expressed by any number of our people that $600 million as a uncompensated care cost was jeopardizing the reserves of many organizations and literally putting some organizations on the edge of bankruptcy.

The contractors and employers who support these funds, have another consideration to think of today, as mentioned by the first speaker. The cost for the Uncompensated Care Trust Fund at the conclusion of this year is in excess of $900 million. Quite frankly, it is so close to one billion that it is frightening. More importantly, estimations that had been made by the Department of Health indicate that by the year end of 1992, the uncompensated care costs will be in excess of $1.5 billion. They are frightening numbers. They are frightening numbers, in that you have an entire system that is being funded by a decreasing number of contributors.

We have, entering onto this scene, people who are expressing a point of view as an alternative to the proposal, as made by the Commission, that we will consider an alternative of funding the entire operation from general revenues. Well, quite frankly, that is the most shortsighted, self-serving type of response to meeting a medical crisis in New Jersey as I have

ever heard. I think that the idea that an industry, a health care industry nationally, that utilizes $175 billion -- and in New Jersey a mere $17 billion to $25 billion, or approximately $20 billion -- is a nice load to be laying on all taxpayers in the State. Indeed, when the income tax was passed in this State, corporations were untouched. Individuals? Yes.

But we have reached a crisis today in health care wherein there are those who will not pay their fair share, And those that do pay their fair share are being penalized. It's patently unfair, inequitable, and cruel. What is happening is that we are forcing those industries right out of business. I am ashamed -- if you will -- of some of the people in the business community who are distorting the facts and not addressing the real problem of funding a system of care that must be put into place to protect every citizen in this State.

I understand the insurance industry's grave concern. When you're talking $175 billion nationally, and approximately $20 billion in New Jersey, that's a lot of money. The problem that the industry seems to have and the reason for the inaction on the part of a number of segments of the society -- including the Legislature, is, of course, how is this money going to be controlled? Well, quite frankly, the insurance industry's concern is that we have a bunch of new regulations and a bunch of new areas that they have to begin to address that they have never had to address before, and, quite frankly, that industry has never had the types of regulations that are being proposed in this Report. And that, sir, is the main objection of the insurance industry.

They are not opposed to a payroll tax. The vast majority of decent larger employers of this State already pay a health care cost for their employees. They would, under this plan, realize a savings. But regulation of the insurance industry-- Let's not kid ourselves, and let's have it said, because it's very quiet and you don't often hear it voiced--

They don't like regulation. This makes the insurance industry accountable to the people and accountable to a system that over seven million people in this State have to have. Indeed, if we are going to take that system, distort it, stretch it out, and make it more costly for those decent employers who are paying their share of the burden, it's indeed a cruel hoax.

I'm very happy today that you are conducting these hearings, because what you are doing is focusing attention on the problem, and we're indeed very grateful for having the opportunity to come in and express these points of view.

I think I'd like to conclude my testimony by saying, I guess the old ball game -- how health care was delivered in the State of New Jersey -- is over, and indeed, it's a brand-new game. And the new game has new rules. And those new rules will guide us to providing the kind of health care that every citizen in this State deserves.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Marciante. Thank you for your leadership on the issue.

MR. MARCIANTE: Thank you, sir.

SENATOR CODEY: Our next witness is Mr. Lou Scibetta, President of the New Jersey Hospital Association. Good morning, sir.

L O U I S P. S C I B E T T A: Good morning, Mr. Chairman and member of the Committee. I am Louis Scibetta, President of the New Jersey Hospital Association. Thank you very much for giving the Hospital Association the opportunity to comment on the recommendations contained in the Report of the Governor's Commission on Health Care Costs.

The Governor's Commission should be commended for undertaking their six-month review of our health care system in New Jersey, and for tackling some of the tough issues which confront us all. As I noted some months ago, for the first

time in more than a decade, real opportunity for change is at hand for all participants in the hospital industry and in New Jersey's health care delivery system.

Everybody at this time -- hospitals, regulators, payers, labor and industry, legislators, consumer groups -- are now beginning to stop bumping the blame for problems that we all had a hand in creating; problems we should all have a hand in solving.

People are beginning to come to the table with ideas and a new tolerance for change, and perhaps an urgency for significant change to take place soon. Our challenge is to agree on the solutions that will shape the New Jersey health care system for the decade ahead. This is clearly a challenge for government as well, since only providers can deliver good quality, efficient health and hospital services. Government must establish the environment in which this can occur effectively.

The New Jersey Hospital Association is very pleased that a number of the hospital industry's concerns were addressed in the final Report of the Governor's Commission. I would like to expand upon some of those recommendations for change in my testimony today. In particular, I will discuss methods to fund uncompensated care, the need to find new and innovative ways to insure the uninsured, and needed reforms to the hospital reimbursement system. Finally, I would like to address some misinformation about bad debt and hospital collection efforts, and the meaning of charity care.

With 92 recommendations represented in the Governor's Commission Report ranging from tort reform to student loan forgiveness for physicians practicing in medically underserved areas, time certainly doesn't permit me to comment on most of those issues of interest to New Jersey hospitals. Therefore, I would like to confine my remarks, Mr. Chairman, today, to several major topics and assure the Committee that when actual

regulations and draft legislation are introduced, NJHA will certainly respond to those initiatives.

In July, the New Jersey Hospital Association submitted a report to the Governor's Commission. Our report was entitled: "Hospital Regulation at the Turning Point: Opportunity for Change." Our report contained 28 suggestions -- recommendations if you will -- for changing our health care and regulatory system and our reimbursement system. Some of the key suggestions for change and how we arrived at our recommendations, I'd like to review with you.

In March, when our task force was assembled, we reviewed material from other highly regulated states -- as far as the hospital system was concerned. We discussed the type of hospital regulatory system that we would like to see in New Jersey as we turn the corner into a new decade.

Our task force sought out the opinions of other groups who were interested in reforming our current system of hospital regulation. Those groups did include: business, labor, payers, providers, consumer advocates, former regulators, and representatives from the hospital industry in other states.

As I stated during my testimony before the Governor's Commission on June 12, we concluded that, "New Jersey hospitals need to do more than just survive. Hospitals must be able to operate within a system that ensures adequate, equitable, and predictable payment levels, while guaranteeing access to care for New Jerseyans, regardless of their ability to pay."

The most pressing concern of our task force, and the issue which kept the Governor's Commission in lengthy sessions, was the development of a more equitable mechanism for paying for hospital uncompensated care. The New Jersey hospital industry supports the premise that the broader the base of financial support, the more equitable the system will be. The Commission's call for the adoption of an uncompensated care

funding mechanism that involves a payroll deduction of $144 per employee to be paid by the employer, is one such broad-based funding mechanism.

NJHA also believes that the long-term solution to our State's uncompensated care problem lies in reducing the number of uninsured persons who must rely on the Uncompensated Care Trust Fund. So we applaud you and the Governor's Commission for recognizing that insurance coverage must be expanded if we are going to attack the real cause of rising uncompensated care costs.

Incidentally, the single most important issue, and one that must be addressed immediately, is the extension of the uncompensated care pool, as it currently exists. It must be reenacted for implementation on January 1, since it expires on December 31. If it is not continued, the cost to those patients now covered will increase dramatically, and hospital solvency will be threatened. Without this law, in fact, paying patients in these hospitals -- these highly uncompensated care hospitals -- thereby will make matters worse because the paying patients will avoid going to the hospitals that are currently uncompensated care facilities.

The Commission's call for affordable, appropriate insurance products for the small business market makes a good deal of sense. Tax credits or incentives to encourage businesses to provide insurance to their employees should be studied.

Our task force urged State and local agencies to place workers on-site in New Jersey hospitals to enroll more Medicaid-eligible patients. Because of the Federal match, we felt that this suggestion would increase New Jersey's Medicaid funds from the Federal government. The Governor's Commission Report actually expanded on this call for on-site Medicaid assistance workers, suggesting that these workers have the

authority to make on-site eligibility determinations and presumptive eligibility decisions. We strongly agree and support this action.

A bright spot on the recent enacted Federal budget was that this same proposal is now a part of the Federal Medicaid law. This should serve to reduce our uncompensated care expenditures by virtue of expanding the Medicaid program.

Turning now to the State's reimbursement system, we concur with the Commission's assessment that New Jersey needs a hospital payment system which is less complex, which is more perspective, which is predictable, which is more timely in its administration, and which, in fact, limits the number of costly appeals. One of the key components of this system would be a written policy that would establish benchmarks. Benchmarks would provide a uniform standard by which the effectiveness of the hospital regulatory system and the effectiveness of the financial stability of hospitals could be determined. We suggested something like, comparing New Jersey hospitals with the standard of the Northeast: expenses, revenues, and so forth.

Again, we were pleased to note that the Governor's Commission concluded that such benchmarks were necessary.

The backlog of hospital rate appeal threatens the financial viability of many of our hospitals and threatens to strangle the hospital rate-setting process. The Governor's Commission indicated that these appeals must be settled quickly, or we face the continued problem of retroactive rate adjustments which are not in hospitals', payers', or, in fact, the public's best interest.

The Department of Health has recently embarked upon an ambitious program -- as our Commissioner shared with us -- of settlement offers for a logjam of hospitals' outstanding appeals from 1985 to the present time. If the Department of Health's settlement offers represent a fair resolution of past

money owed to hospitals, I am confident that our hospitals will accept the offers and the backlog, and the logjam can be cleared. However, if the offers are not fair, the unacceptable status quo obviously will continue, and nobody wants that.

As we highlighted in our task force report this summer, Mr. Chairman and members of the Committee, one of the elements of the current regulatory system which we find counterproductive is excessive control to a regulated industry, and, in this case, historically by and through the Department of Health. Too much authority concentrated in one jurisdiction which reduces local input and often negates the more meaningful role of hospital boards and management, is not helping. This excessive control has led to the type of micromanagement of hospitals which is costly and inefficient.

I fear that some of the Commission's proposals in the health care planning and regulatory arena exacerbate this trend toward micromanagement. I hope that we can work with you and the Department to arrive at a regulatory system for hospitals which is both effective and efficient.

Finally, I want to address the issue of bad debt and charity care, the two often-confused components of uncompensated care. New Jersey hospitals are doing a good job of collecting bad debts from patients who will not pay their bills, in part because the same law that established the Trust Fund also imposed on hospitals the most rigorous credit and collections regulations in the country. Hospitals in New Jersey follow a 17-step admissions registration process and a 23-step collection process that include collection phone calls, letters, telegrams, and legal action to recover bad-debt moneys -- a process that business would be awed at.

Also, the State continually audits hospitals' uncompensated care claims. If a claim is found not to be valid, the hospital simply doesn't receive payment.

New Jersey limits what is called "free care" to only those individuals earning less than 150% of the Federal poverty income guidelines. Therefore, as an example: A family of three earning more than $15,840 would not qualify for charity care, even if they were faced with a $50,000 bill. They obviously would be hard-pressed to pay for a large hospital bill and related expenses, and obviously they'd be hard-pressed for even the small hospital bill at those income levels. This is a problem.

So to summarize: Since the State's charity care income-eligibility requirements are so stringent, uncollectible and unpaid bills are rarely classified as charity care and are erroneously classified as bad debt.

In closing, I would like to thank you, Chairman Codey, and members of the Committee, for giving the New Jersey Hospital Association the opportunity to testify today. We very much appreciate your interest in attempting to solve some of the pressing health care issues in New Jersey, and we look forward to lending our hand towards some of the meaningful solutions. Thank you very much.

SENATOR CODEY: Mr. Scibetta, you mentioned the issue of the collection of bad debt. What do you consider the good collection of bad debt?

MR. SCIBETTA: Well, the process by which hospitals are involved with -- in terms of the collection process -- is being efficiently and effectively administered. That's the point I wanted to make. And oftentimes there is great confusion about what, in fact, is charity care and what is bad debt. Most of what has been currently termed bad debt is, in fact, charity care. It simply involves around this definition of what charity care is.

Charity care is much more than a family of three making $15,880. In our State, if a family in that situation doesn't pay a bill, that's considered a bad debt. Well, that

in fact really is charity care. Those people simply can't pay the bill, so we have a misnomer in terms of classification, and much to the credit of our government right now, we're trying to define better and understand better what some of the demographic characteristics of those people are; how much they make, and where they are in--

SENATOR CODEY: What has the State denied in those areas?

MR. SCIBETTA: What have they denied?

SENATOR CODEY: Right.

MR. SCIBETTA: I don't know that the State has denied payment. I think that this has led to a comment that suggests that hospitals have too much bad debt, as opposed to the fact that what we should be saying is that there is too much -- because the allegation that hospitals aren't doing a good job in collecting that money-- The comment that should be made is that our charity care levels are very high. It is a very, very high cost State; a very high income State. The cost of living and the standard of living are second, in New Jersey.

SENATOR CODEY: But we have a system whereby you are guaranteed to be reimbursed, so obviously someone would make the argument that there's no incentive to effectively chase your debt.

MR. SCIBETTA: Senator, I know. We hear that. We hear that statement all the time. I just want to state that we have proposed, and continue to propose, whatever considerable audits ought to be undertaken in order to determine whether or not hospitals are doing the kind of job they are expected to do. We have a great deal of confidence in the Board of Trustees, in their oversight in our hospitals, that the kind of activities that are supposed to take place, are taking place.

Hospitals have every good reason to want to collect the funds. The reason that it is guaranteed should be underscored. The reason that bad debt and charity care are

guaranteed for our hospitals in New Jersey is unlike what happens across the river -- the Delaware River -- in Philadelphia, and elsewhere. Every single nickel that a hospital can collect is regulated by the State of New Jersey. They can't charge an add-on. They can't get a commercial insurer and add another charge to that commercial insurer or to another patient, whether they're insured or not for their bad debts. They can't do that in New Jersey. If the bad debt process and the charity care process are not integral to the payment system for hospitals, we're simply not going to have solvent hospitals.

That's precisely why this Legislature, in its wisdom, passed the uncompensated care legislation which is so critical to both the health and the welfare of our eight million residents, as well as the ability for hospitals to continue to be there and serve as, in fact, the point of service for our millions of people who need hospital care.

SENATOR CODEY: Mr. Scibetta, the Report mentions granting a 2% operating margin. Would you agree that that is a fair percentage?

MR. SCIBETTA: The operating margin-- The nationally recognized standard, Senator, of a minimum operating margin, is considered to be no less than 4%. This is not something I'm quoting to you from what the New Jersey Hospital Association says, or what the New Jersey hospitals have said. This is a national standard that has been published and publicized and recognized.

SENATOR CODEY: Who recognizes that as a standard?

MR. SCIBETTA: The authorities who are considered experts in hospital finance in the schools of higher learning who publish papers. We'd be happy to get you a copy of that for you to review. I think we have shared that with certain parties in government.

SENATOR CODEY: Does that take into account the fact that here in New Jersey we guarantee bad debt?

MR. SCIBETTA: It takes into account what kind of money is needed in order to have any entity that is considered a business, that must concern itself -- or an organization that must concern itself -- with future development, technological expansion, meeting the needs of changing health care services throughout this nation-- And the answer is, yes.

SENATOR CODEY: Certainly, I think, someone would make the argument that if you are guaranteed your bad debt, if you're guaranteed the 2% operating margin, that it wouldn't be too hard to run the business?

MR. SCIBETTA: Well, it's very hard to run any business. But I think that--

SENATOR CODEY: Well, it's a lot easier if the bad debt is guaranteed, and you're guaranteed a 2% operating margin.

MR. SCIBETTA: Well, an operating margin assumes the margin on the operations of covering all of the expenses that it must incur in order to be profitable. So by definition, the cost of doing business-- I'm certain any businessperson in this State would agree with my statement. The cost of doing business includes the cost of collecting the debts that aren't paid by one party -- from one party to another. That's the cost of doing business, a normal cost of doing business. It's a normal cost of keeping a hospital afloat, so that an operating margin over and above that cost, Senator, is what is being addressed in the recommendation.

Now, I would hasten to point out that New Jersey hospitals have, for a period of the last two decades, operated at well below national standards of margins; well below the ability to have additional revenues to meet the future considerations. But that is considered the standard. Now, some states and some hospitals are going to have 6%, 8%, 10%.

Some are going to have 3%, or perhaps as low as 2%. We've had .5%, as you know, Senator, and that has been just an awesome point of contention.

SENATOR CODEY: What if we said to you: Forget about the rules regulating the collection of bad debt. We'll wipe them out, but you can only write off a certain percentage. What effect would that have?

MR. SCIBETTA: I think you would have to, at the same time, suggest that if you wanted to do that, that hospitals could then make charges to patients to cover the costs that are not being paid for through some other revenue source. You'd have 100% of the expenses--

SENATOR CODEY: No, that sounds like you still want to guarantee it.

MR. SCIBETTA: Well, as long as the State has assumed the responsibility for controlling 100% of the revenues which hospitals can receive, then absolutely, we would assume a responsible regulator would want to make certain that we have a healthy industry, and that they collect a dollar in order to pay a dollar, and that there is at least a few crumbs left in order to plan for the future.

I don't know that this is unusual for any business that wants to stay in business. And what is at risk is the health care of the population of the State of New Jersey. We have probably the finest group of hospitals in the country, right here in this State. It has taken a long time to get there and we would be very, very concerned if there was any movement to diminish the revenues that hospitals receive, since they have historically been treated--

You know, if you take the entire northeast quadrant, and you compare the revenues, per case, that our hospitals receive, we would rank dead last out of these 10 states. If you take all of the industrialized states, and you take the revenues that hospitals receive in New Jersey, per case, we

rank dead last among all of the industrialized states. So it isn't that hospitals are asking to be rewarded so that they can pay dividends. They want to pay bills, and they want to be able to know that tomorrow when they have a nursing crisis, or a crisis of other personnel, or there is a technological advance that needs to be in our hospital so that people don't have to go to very expensive settings -- such as Philadelphia, New York, eastern Pennsylvania, and others, where rates are not controlled; that our hospitals can provide those services to our residents.

I think that is what we would term to be a public/private sector rational approach to regulating health care in the hospital industry.

SENATOR CODEY: Thank you very much, Mr. Scibetta.

MR. SCIBETTA: Thank you, Senator. Thank you very much.

SENATOR CODEY: Our next witnesses will be Donald Daniels, Chairman of the Board of Blue Cross/Blue Shield of New Jersey, and Dr. John Petillo, President and Chief Operating Officer of Blue Cross/Blue Shield of New Jersey.

D O N A L D M. D A N I E L S: Thank you, Senator, members of the Committee. I'm Don Daniels, and with your indulgence, I would like to have John Petillo just give a overview of our comments. Written testimony will be submitted, and then we would like to stand for questions.

J O H N J. P E T I L L O, Ph.D.: Senator Codey, members of the Committee, we certainly thank you for this opportunity to speak before you. We'd like to thank and also acknowledge Senator Codey for his role in not only convening this hearing, but certainly his work in the Commission.

As Mr. Daniels has said, prepared remarks have been distributed. I will not read those remarks now, and will try to just make comments that are much briefer.

Don Daniels and I have testified before a variety of commissions and groups over the past nine months, to discuss the crisis in health care. You've heard the Commission -- the Health Care Commission's report, and you're aware of their recommendations. Many of those recommendations deal with the controversial financial and administrative mechanisms necessary to avoid a collapse in the health care crisis. Others deal more specifically with the financial viability of Blue Cross/Blue Shield of New Jersey.

We cannot lose sight of the latter because of our necessary preoccupation with the former. I would suggest as we are before you today, that there are many things that we can do to substantially reform the system that do not require new revenues:

1) The splitting of Blue Cross/Blue Shield to create two entities -- one to serve the large group sector and the second to serve the public policy sector.

2) To create a level playing field for the individual sector of the business -- for the public interest business, so that all carriers write by the same rules.

3) Develop bare-bones coverages. We have done that, and will file that with the Department of Insurance very shortly.

4) Get the grass-root causes of increased costs by encouraging quality care through a managed care approach.

Once again, group managed care, point of service products, has been on file now with the Department of Insurance, for us. And we are discussing means of making available such managed care projects for the nongroup.

We at Blue Cross/Blue Shield have taken other steps because of this crisis which directly affects us. This morning's papers have covered those steps:

1) the downsizing of personnel to save costs, and to adjust to our enrollment base;

2) to significantly cut the 1991 operating salary budget; and

3) for our own management employees to shift to a managed care coverage, which would then require employees to share in the cost of the health care benefits.

Those steps will save Blue Cross/Blue Shield of New Jersey during the next fiscal year $37 million. Because many of the reforms that I mentioned previously are not in place, tomorrow we will have to file for a significant rate increase for the individual market. We are certainly aware that many people cannot presently afford these rates, and more will not be able to afford these rates after the increase.

Unfortunately, because of the 1988 Recovery Act, we have financial responsibility and obligation towards the solvency, to file. We have now before us a small window of opportunity. I would suggest to this Committee that to reduce that rate hike-- If some of the reforms that I have addressed previously are taken, a significant portion of that rate increase request can be reduced. But those reforms -- those reforms which are not financially impacting upon the State budget need to be in place.

We can only encourage and strongly request public action as soon as possible. At this point, we'd like to answer any of your questions, Senator, or members of the Committee?

SENATOR CODEY: Yes. You have a rate increase coming up. Can you tell us in a ballpark figure what that would be?

MR. DANIELS: Yes. Tomorrow we will be filing a rate increase for individual subscribers -- those are subscribers who pay their premium on their own -- and that will be in the amount of 47.3% for an effective date of 1 January 1991; to be implemented effective 15 February 1991, which will run for a one-year period.

SENATOR CODEY: Okay. Let's assume that today we didn't have the uncompensated care funded as we do now, but

say, for example, we had a payroll tax. What percentage would you be seeking?

MR. DANIELS: The elimination of uncompensated care alone would probably--

SENATOR CODEY: We're not eliminating uncompensated care, we'd just be changing the mechanism.

MR. DANIELS: Mechanism of funding?

SENATOR CODEY: Right.

MR. DANIELS: Through the additional 19% tax on -- soon to be 23% or 26%. If that were to be eliminated, you could probably reduce total premium in the area of 5% to 7% or 8%. Now, if you coupled that with just as heavy a burden -- and that is Medicare shortfall, which is also another billion dollars -- you're in the same neighborhood.

You've got, in 1992, added to the health care system of New Jersey, in excess of $2 billion for uncompensated care and Medicare shortfall.

SENATOR CODEY: Okay. What effect will the announcements yesterday have on the pure cost of doing business, in terms of downsizing your corporation to meet what is now your subscription base?

MR. DANIELS: Well, as Dr. Petillo mentioned, we have cut back some $36 million in our operating expense budget for next year. We've been always proud that our operating expense, administrative expense, has been the lowest in the State. This will lower it that much more. As it relates to this individual class of business, this 47% increase which represents about 18% of our business-- That will reduce the rate requirement in excess of $8 million for that part of the loan.

SENATOR CODEY: In regard to the individual small employer company, what are your projected losses for '90 and '91?

MR. DANIELS: If you'd asked the question on individuals, at this point I could answer you. Right now the

individual class of business is segregated. We will lose -- for the individual class of business in 1990 -- approximately $30 million to $35 million, where on the recovery plan, we were required to show some profit this year on that part of the business. Without a rate increase, which we will be applying for, we would lose over $200 million in 1991, if none of that rate increase were granted.

SENATOR CODEY: Okay. What would happen if we separated the companies?

MR. DANIELS: Great opportunities. By separating the companies you would give very clear focus to the public side of business as well as the private side. I think separating the company gives great opportunity, not only to make certain that focus is there, but I believe the regulation has to be intensified to make certain that all payers -- all customers who are paying that money -- are receiving back at least 80% of their health care dollar.

In doing that, obviously we require a level playing field for all insurers who want to write in that business. Right now, insurers are coming and taking the cream of the crop -- if you will -- and taking the better risk and leaving to us and to the people who are paying for it, poor risk, by raising the premiums. That's anti-selectional. I think that provides that.

At the same time, I think that the makeup of 47%-- I have to mention that in that 47%, 13.3% is for financial recovery; in other words, reserve contribution. It seems to me that we've reached a point of such a crisis in this State that the legislation should be -- for the public policy role -- extended. The recovery program should be extended, so that at least some relief from that 13% can be granted.

SENATOR CODEY: What's your deadline right now?

MR. DANIELS: It's December 31, 1992 for both the group side and the private side. I would mention that we're

right on target for the group side of the business. We have reduced our deficit from $280 million, and at the end of this year we will be at about $145 million, which has been coming totally from the group side of the business.

If we can extend the recovery program for the public side of the business, that will also add relief to the individual subscribers. So that, coupled with equal regulation, is a great advantage.

The other thing that I would submit is, by segregating the company, there are many opportunities for very innovative financial funding for the public side of the business. And, what am I talking about? Obviously, any injection of external funding in the form of a payroll tax, in the form of any relief that would come to reduce uncompensated care or Medicaid shortfall, would help the individuals directly. At the same time, we have had employed in this State for many years -- 40 years at least -- the use of a hospital discount; differential, if you will -- that has been granted and given directly to subsidize the rates of individual customers.

This year, in 1990, we are subsidizing through that differential individual classes of business by some $42 million. I would submit that that is another way of abating some of the rate requests and rate requirements needed. I'm sure there are other avenues that everyone speaking together can start employing.

SENATOR CODEY: Could you please explain what you feel is a competitive disadvantage under community rating?

MR. DANIELS: I don't think there would be a competitive disadvantage under community rating, if everyone was required to do it. The problem right now is that we, at Blue Cross/Blue Shield alone, are required to take all individual subscribers, regardless of health. We are required to do that on a community-rated base. All other insurers who select to write that type of business are given the opportunity

and privilege of writing on a demographic basis. What that really means is that younger people, who presumably are healthier, will receive a lower rate. In doing that, the people in our pool who are at the lower end of the age and a better risk, will defect to the commercial, and what happens is that the people left in the pool are anti selective against, and higher rates go in.

I believe that anyone who writes public policy business in this State -- be it individual or small groups -- should be required to community rate.

SENATOR CODEY: You had recently announced the offering of a bare-bones package of insurance. Could you explain what that contains?

MR. DANIELS: Yes. And we will file that tomorrow, concurrently with the rate increase. What that basically would contain is 30 days of inpatient care, including maternity benefits. It would cover outpatient for surgery only. Under the physician side of the business it would cover surgery, medical care, and anesthesia. It would also have a major medical type of coverage with a $500 deductible. What it would exclude are: psychiatric benefits, substance abuse benefits, and mandated benefits. At the same time, it would exclude such benefits as lab, x-ray, and office visits.

This does provide, I think, very outstanding coverage for some 95% of the population. We talk about 30 days of hospital care. I believe the number currently is that 95% of all admissions in this State are less than 30 days.

SENATOR CODEY: Well, isn't the average length of stay roughly about a week?

MR. DANIELS: About 6.7 days, yes.

SENATOR CODEY: So why offer a package that provides 28 days?

MR. DANIELS: Well, there are many, many people who stay in excess of that six to seven days. Thirty days gives, I

think, a very secure level of comfort, and does provide for people who would require that. At the same time, we can provide a rider, if you will, for preventative care benefits, and that, I think, has a lot of attraction. When we're talking about preventative care, we could be talking about physical exams, immunizations, related diagnostic tests, patient education, things of that nature.

SENATOR CODEY: Well the more you put on it, the less it becomes bare?

MR. DANIELS: The more you put on it, the less it becomes bare. But that protects, where a preventative package could be added for perhaps $100 a year.

SENATOR CODEY: What would the cost of this package be?

MR. DANIELS: We could offer this package that we're proposing, at about 50% less than what the current packages are. If I could give an example: We have single coverage -- people who are single. We have family coverage. If you composite those rates currently, without the filed increase, that would perhaps be about $4800 a year on a composite rate. We can provide the coverage I just detailed for some $2500 a year.

SENATOR CODEY: Well, suppose you knock the 28 to 21. What would that do in terms of dollars?

MR. DANIELS: As far as hospital days?

SENATOR CODEY: Yes.

MR. DANIELS: It really wouldn't impact it that dramatically. It would just be a few dollars.

SENATOR CODEY: A few hundred dollars, or--

MR. DANIELS: No, no, no, no. I would guess not much more--

SENATOR CODEY: You wouldn't be able to knock every day down to a dollar amount?

MR. DANIELS: No, no, no.

SENATOR CODEY: What happens a year from today if we don't do any hing in regard to the Blue Cross/Blue Shield recommendations?

MR. DANIELS: What happens of course is if you don't do anything, and if the Commissioner of Insurance doesn't do anything, as it relates to rate increase, there will be no Blue Cross/Blue Shield plan. And you won't have to wait a year from today, because we are mandated by legislation to be back to solvency and, indeed, have a two-and-a-half percent surplus by December 31, 1992.

We are in conditional approval for the use of the name and trademark from the national Blue Cross/Blue Shield Plan. That condition is based on us meeting the finance recovery plan which is mandated by legislation, which has been filed with, and approved by, the Commissioner of Insurance, which we are meeting.

If, at any point, there is indication that that recovery plan cannot be met, I'm sure that the name and trademark will be removed.

SENATOR CODEY: Okay. Thank you very much, gentlemen. Our next witness is Mr. Marc Lory, Vice President of UMDNJ.

M A R C H. L O R Y: Chairman Codey, and members of the Senate Institutions, Health and Welfare Committee, thank you for the opportunity to comment on the recommendations of the Governor's Commission on Health Care Costs. My name is Marc Lory. I am Vice President and Chief Executive Officer of the University Hospital, part of UMDNJ in Newark.

I would like to specifically address the issue of uncompensated care and the Commission's astute observations about the current system of financing this growing component of our health care bill.

First, let me make it absolutely clear that I believe emphatically that the concept of reimbursing hospitals for

their uncompensated care costs must be protected. Several years ago, the State of New Jersey took a bold step, both eminently pragmatic and humane, when it was resolved that no man, woman, or child would be denied hospital treatment due to their inability to pay. We cannot tamper with the safety net that uncompensated care financing provides for our citizens and our hospitals, or else we will fall prey to the same disasters we see in states throughout the country as trauma systems collapse, patient dumping becomes an accepted way of doing business, and handfuls of public hospitals are continually overwhelmed.

The decision to establish the Uncompensated Care Trust Fund was a good one. It removed the inbred competitive disadvantage suffered by our urban hospitals, while protecting the rights of the medically underserved. We should not disown this initiative simply because the luxury of hindsight now allows us to see that our preoccupation with financing the expense of the delivery innovation has brought us to the brink of disaster. True, the Fund's current tax on those who pay their hospital bills is a perverse catch-22, as inequitable as it is foolish, but the Governor's Commission has outlined a workable strategy for taking us back from the brink, and I urge you to give careful consideration to those recommendations.

This year, University Hospital drew down some $30 million from the Uncompensated Care Trust Fund. Much of that $30 million will go to the truly disenfranchised of our society -- drug-addicted newborns, homeless AIDS patients, and young men and women who both create and fall prey to violence in our streets. But much of the greater proportion will go to the working men and women and their dependents -- individuals and families struggling to get by in this era of high-cost housing. Their employers cannot, or will not, provide health insurance, and the costs of buying individual policies are too high. These are the working poor, and the Uncompensated Care

Trust Fund has protected them from the inequities that our society imposes upon those who cannot pay their own way.

The Commission recommends that Medicaid eligibility be expanded to the fullest extent allowable by law as a means of reducing the uncompensated care bill. By doing so, many of the working poor would be covered, and the cost of their health care would be shared by the Federal government.

The Commission recommends that small businesses and individuals be assisted in purchasing health insurance through a public purpose, managed care product. By doing so, many more employees and dependents would be covered and the cost of their health care would be supported by the premiums that are community rated.

The Commission recommends that a small payroll tax be implemented to cover the cost of any residual uncompensated care. By doing so, the tax on insurance bills can be removed, and the costs borne more equitably among all employees and employers.

I would add one other recommendation to those offered by the Commission, and that is to include physician payment, as part of the costs covered by the Trust Fund. Right now, those who cannot afford to pay for their health care are effectively excluded from private, community-based services. Instead, the uncompensated care payment system directs them to hospital-based clinics where costs can be two to three times higher than a visit to a local practitioner's office. By including the physician reimbursement, patients will truly have equal access to the most appropriate health care setting.

These recommendations are as bold and as fair as our original commitment to finance uncompensated care, but more carefully link the public and private sectors in financing and clearly insist on innovation in delivery models. Carefully implemented, these recommendations can protect the underserved, while maintaining our business community's competitive position.

It will take time for these recommendations to go into effect and earn the savings expected of them. In the interim, poor people will continue to get sick and will continue to seek treatment in our State's hospitals. Therefore, I urge you to continue the current system of financing uncompensated care -- that is, the Uncompensated Care Trust Fund -- for another 24-month period.

We have before us a blueprint for the future. As we prepare to enter a new era in New Jersey's health care system, we must resist the temptation to renounce the present and return to the past. We know what must be done. Let's preserve what is good and create what is much better.

SENATOR McMANIMON: Thank you very much. Marc, you mentioned that much of the uncompensated care dollars received will go for drug-addicted newborns and AIDS patients. What is it going to take to qualify these patients for Medicaid?

MR. LORY: We have a Social Work Department, and we work closely with the Medicaid office in the City of Newark. One of the problems we experience in that process is the fact that the patient population that takes advantage of Medicaid has difficulty with compliance, and by forcing or making that client go from our hospital to a downtown Medicaid office, we lose the capability of insuring that that patient actually enrolls in the Medicaid system.

So I would say that a good portion of these patients -- especially if you move in the recommendation of the Commission of expanding eligibility for this population-- I think you need to also address how to make it easier for them to register into the system, something that we still don't have a handle on.

SENATOR McMANIMON: What percentage of uncompensated care is bad debt and charity care?

MR. LORY: I would say approximately 40% would be classified as bad debt, and probably 60% -- in my institution -- is charity care.

SENATOR McMANIMON: All right. Thank you very much.

MR. LORY: You're welcome.

SENATOR McMANIMON: Our next witness will be Dr. Douglas Costabile, President, Medical Society of New Jersey.

D O U G L A S M. C O S T A B I L E, M.D.: My name is Douglas Costabile. As President of the Medical Society, I speak for some 10,000 physicians whose medical practices, ability to care for patients, and livelihoods will be strongly influenced by the actions which the Legislature chooses to take in response to the Commission Report.

Fifty pages and 92 recommendations: That's a lot for anyone to digest. Some of the recommendations, such as revamping the DRG system, show potential for moderating the cost of health care. Others, such as limiting physician dispensing to a five-day supply of medication, are narrowly focused, and should have little, if any, impact on costs.

But all of us recognize that the Commission did address the single most important health care issue which faces our State: The Uncompensated Care Trust Fund. If you can resolve this problem and stab lize or reduce the cost of health insurance, you will have achieved fundamental reform. All of the other recommendations are interesting; they are worthy of discussing. Some we like, some we don't, but they all take a back seat to uncompensated care.

Why are doctors concerned? As health care insurance becomes less affordable, more of our citizens will become charity cases. They become an enormous burden on the employers and individuals who still have health insurance. And as their numbers increase, uncompensated care patients threaten the economic viability of our hospitals. Without hospitals, physicians can't practice medicine.

The Commission clearly points out that our citizens no longer can afford to finance uncompensated care with surcharges

on hospital bills. The Medicare surcharge is burden enough. The uncompensated care surcharge is overwhelming.

Doctors, as you probably know, are not part of the uncompensated care problem. From the beginning of the program, up to the present, we've been part of the solution. We aren't paid for our services to uncompensated care patients in hospitals, and the Health Department estimates that we are currently donating $500 million annually in free care to these patients. There is no law or regulation which says that physicians must donate their services. But absent a law or regulation to the contrary, that's how it turned out. Our $500 million donation nearly approximates the amount of the Fund itself. This is no small burden.

The Commission recommends a payroll tax on all employees, plus a penalty on employers who do not provide health insurance. Given the antitax climate in this State, this was a courageous decision. We certainly think it's worth discussing. It may be the fairest, most expeditious way to prevent health insurance from becoming a luxury.

There may be other methods of financing uncompensated care. If the number of uninsured citizens is reduced, perhaps the Fund will shrink to a size where it can be supported with general revenues. So how do we reduce the number of uninsured people? How does the Legislature make health insurance affordable?

We think that the Legislature should pursue two initiatives simultaneously with its refinancing of the Fund:

One, Mr. Chairman, is your suggestion to create less expensive hospitalization insurance by giving carriers the opportunity to offer a no frills policy.

The other is to require a reduction in health insurance premiums proportional to the amount that is saved from repealing the uncompensated care surcharge on hospital bills. If you don't mandate this health dividend, we may never

see lower premiums. Think for a moment about what happened to health insurance premiums when the automobile no-fault law was enacted years ago. Although the law relieved health insurance, of the medical and hospital costs of people injured in automobile accidents, we don't recall paying lower health insurance premiums.

The point is, anything you can do to make insurance affordable will go a long way toward solving the uncompensated care dilemma.

Let me now mention some of the Commission recommendations which the Medical Society finds troubling -- particularly if their goal is cost containment:

1) Bringing more providers -- specifically physicians -- into the Certificate of Need process: The report says this will have all providers compete on a level playing field, but we know whose field it is; the hospitals'. There's an old expression: "Never try to beat a guy at his own game." The Certificate of Need process is very much the hospitals' game. They have the accountants, the consultants, the lawyers, and the public relations people it takes to massage a Certificate of Need application through the time-consuming process. So if physicians are required to compete for a Certificate of Need, the likelihood is that they'll lose most of the time.

We think this would make health care -- particularly diagnostic procedures -- more expensive. We all recognize that hospitals have high overhead expenses. Thus, even simple procedures that are performed in hospitals command high reimbursement rates. If, through the Certificate of Need process, hospitals gain a monopoly on state-of-the-art equipment, the public will pay more. Is the so-called, level playing field worth the added expense?

2) Prohibiting physicians from referring patients to services in which they have a financial interest: This recommendation is based on a suspicion that doctors are

ordering tests or treatment that are unnecessary, simply for financial gain. But other than a study done in northern California, we haven't heard of any factual evidence to support that suspicion.

It may very well be that doctors send more of their patients to a service when they have a financial interest in that service. But are they ordering more tests or treatment than they did before they made the investment? That should be the question. From the patient's viewpoint, the issue is: Was the treatment necessary, and was the price reasonable? If the treatment is not necessary, we're really dealing with consumer fraud. We already have laws and regulations which punish such wrongdoing. If the price is not reasonable, insurance won't cover the full amount and the patient can refuse to pay the balance.

I'd like also to emphasize that in many instances, physicians made these investments because they saw a need which wasn't being met in their communities. In some cases, they were urged by their hospitals to build a facility to render state-of-the-art care, such as a cardiac rehabilitation center. If the treatment is necessary and the cost is reasonable, it seems grossly unfair to us to prohibit patient referral.

3) "Rebundling" physician reimbursement for hospital services into hospital bills: If there's a silver lining here, we suppose it's the possibility that physicians might receive something for the uncompensated care which they donate today. On the other hand, this recommendation would place our livelihoods at the mercy of the DRG people in the Health Department. Given the State's experience with DRGs, I doubt there's a person in this room who would welcome that fate. We certainly don't. If our hospital administrators negotiate passionately in our behalf, and if the DRG rate setters are inclined to be fair, perhaps we have nothing to fear. But that's a big "if."

In any event, "rebundling" will produce higher hospital bills, and the public will be puzzled, to say the least. And, because Medicare will not participate in "rebundling," doctors will still have to maintain the capability to bill patients directly for their hospital services. On balance, we're opposed to "rebundling."

4) Mandatory Medicare Assignment: We know of no one, patient or provider, who is pleased with the Medicare program. And it's only going to get worse. None of us, including the Legislature, can do a thing about Medicare rates, premiums, or copays. That's strictly in the hands of Congress.

To understand why physicians are opposed to mandatory assignment, bear in mind that Medicare has evolved into a two-tier reimbursement system. The higher rate is called the Maximum Allowable Average Charge. It's 10% to 15% below the physician's usual fee, and it's the most that can be charged to a Medicare patient. Still lower is the assignment rate. Medicare offered physicians this incentive when it developed the lower rate: If you charge less, we'll process the claim more quickly and reimburse you directly, instead of through the patient.

As Medicare grew more complex and sluggish throughout the 1980s, long delays became commonplace. Thus, the incentive for accepting assignment evaporated. Nevertheless, as a consideration for their patients, physicians continue to accept assignment.

This is where the Commission report ignores the truth. It says that only 29% of our physicians accept assignment. And it says that seniors are paying overcharges.

The fact is, 75% of the Medicare bills in New Jersey are charged at the assignment rate. And the remaining bills aren't overcharges as the Commission states. They are allowable charges, below customary rates, as fixed and enforced by the Medicare program.

While 29% of our physicians accept assignment for all patients, the fact is that all physicians accept assignment for some patients. If a senior is qualified for PAAD, or if the senior needs help, even though his or her income exceeds the PAAD limits, our Senior Medical Courtesy Program will find a conveniently located physician who will accept assignment.

If the senior doesn't need financial help -- if we're treating a Lee Iacocca -- physicians feel that they should have the option to charge the MAAC rate. Bear in mind that it's still 10% to 15% less than the usual charge.

We can understand why the Commission is concerned about needy senior citizens. We're concerned, too. And we've already developed a program to help this segment of the senior population. If the PAAD means test is inadequate, please suggest another for us to consider. But we don't believe it's either fair or equitable to mandate assignment for some seniors who are far more financially secure than the average New Jersey working man or woman.

Finally, I'd like to leave with you some copies of "Health Access New Jersey," a plan developed by the Medical Society which suggests a number of ways to expand access to care for those persons who have no insurance or who lack adequate insurance. We look on today as a beginning of a dialogue with key legislators who have been saddled with this enormous burden -- and a great opportunity -- to help keep health care in New Jersey at a high level.

We hope to cooperate in every way, and look forward to continuing the dialogue. I thank you for the opportunity to speak to the Committee. We trust that we can continue to be of service to you. Thank you.

SENATOR CODEY: Thank you very much, Doctor. Our next witness is Dr. Robert Maurer, Medical Society of New Jersey. Dr. Maurer?

R O B E R T S. M A U R E R, D.O.: You've just heard a presentation by the President of the Medical Society of New Jersey, and you will get a written presentation by the President of the Osteopathic Society of New Jersey. There are also other physicians that will be testifying here today.

I've come here for one particular reason, and that is to address an issue that has not yet been addressed here this morning. All of the previous witnesses, from the Commissioners on down to Blue Cross representatives, the Hospital Association, and so forth, have all talked about what seems to be the major issue in the health Commission Report, which is the funding of the deficit, which I hear is at some figure between $500 million and almost up to a billion, as Mr. Marciante testified.

Of course, we have to address the deficit, but there is a driving force that has made the amount of dollars in that deficit intolerable. The cost of health care costs are uncontrollable, and one of the major driving forces is the medical malpractice situation as it exists now in the State -- in the country.

Medical malpractice drives physicians and drives the diagnostic-oriented system that we now have. Now, I bought along a rate sheet of costs, because physicians formed their own insurance company back in 1977. We feel proud of the fact that we have been able to make insurance affordable and available for all physicians in the State. Now, whether you think that a $55,000 premium for neurosurgeons, or a $42,000 premium for obstetricians is affordable, of course is debatable.

We've testified in this room before the Judiciary Committee on what percentage of that premium is related to the doctor's income, which really is not the issue. The issue is that the premium that the doctor pays is reflected in his billing to the patient. The $100 million a year that the Medical Inter-Insurance Exchange collects, plus the additional

$100 million from the Princeton Insurance Company -- and other insurance to insure doctors -- about 35% of which gets into the hands of injured parties and about 65% of which goes to attorney fees and to run the system-- That $200 million is reflected in higher costs to patients, because of costs-- Patients eventually pay doctors' overhead charges. But there really is a much more significant figure than the $200 million in insurance premiums that the physician pays. Those two areas are:

1) The psychological behavior of the physician -- when he is sued in a medical malpractice case and that case encompasses his entire mind and prevents him from properly treating all of the future patients that come to him, because of this overwhelming situation he's been placed into.

2) The most significant figure is the $1 million -- excuse me, the $1 billion a year that some of us estimate to be the cost in the State of New Jersey for defensive medicine; a figure that reflects to about $40 billion a year in the United States.

Defensive medicine costs $1 billion, and, coincidentally, Mr. Marciante, that comes very close to what we've identified as the deficit. I feel that this Committee should recognize that the medical malpractice fear and the medical malpractice excuse is what drives many of the medical care costs up to the current situation.

I really wear two hats now: After 25, 26 years of general practice, I now do work for the physicians' insurance company, and work on their Legislative and Risk Prevention Programs. But I also do Utilization Review for a 650-bed medical hospital -- the John F. Kennedy Center in Edison, New Jersey. In that role, I am on the phone daily with 10, 15, 20 physicians, trying to talk to them about releasing patients from the hospital early, about overutilization of tests, overutilization of ancillary services, and all of those things

that drive medical costs up. And I can tell you that in my role as Utilization Review Chairman, it's a direct conflict with my role, working for Risk Prevention, for the Inter-Insurance Exchange.

In my Risk Prevention role, we tell physicians to order every test available. We tell physicians to do caesarean sections at the slightest complication. We have a caesarean section rate, in New Jersey, of 28% today. And we estimate that that figure should be 5% to 6%. We have the number one cause of medical malpractice today: It is failure to diagnose, specifically failure to diagnose breast tumors, and number two, are damaged babies.

Because of that, what we do is, we advise our physicians to order, order, order. Order CAT scans, order MRIs, order every test possible, because the lack of ordering a test is indefensible many times in a litigation court.

On the other hand, as a utilization reviewer, I implore my physicians to cut back on their testing, on their ordering, on their caesarean sections, on the various procedures that they do, in order to control the costs of health care. And those two areas are in direct conflict.

I will tell you, as a final note, that when I call my physicians and I ask them to discharge a patient early, or what can we do to cut the cost of this patient's care in the hospital, the answer to me invariably is: "Dr. Maurer, I don't want to get sued. I'm ordering this test to cover myself. I'm keeping the patient in the hospital a couple of more days, because he or she may go home and may fall, or may suffer some other reoccurrence."

Whatever it is, we are dealing with a massive conflict between utilization review and medical malpractice. I implore this Committee to address that issue in its deliberations, because certainly we must fund a deficit, but almost as important -- if not more important -- is if we can control the

cost of medical care. We physicians are asking you to help us reduce the amount of money that we are spending in the system. We cannot do that unless we address the medical malpractice issue, and I've stated several of those remarks in my note to you.

Thank you.

SENATOR CODEY: Doctor, isn't it a fact that the cost of malpractice insurance has gone down in the last few years?

DR. MAURER: We are in a catch-22. We have done something that I think is magnificent, and have not gotten the appropriate credit for it. In 1977, medical malpractice insurance was going through the roof, and was unaffordable and unavailable. By us creating a physician-owned company under the auspices of the Medical Society, insuring 8000 doctors, we put a control on the situation. We have quality control. We have risk management. We have peer review. We have insurance and underwriting review.

We do what I think is a great job in bringing down the medical malpractice claims across-the-board. We know that frequency has leveled off, but severity has doubled or tripled. We had nine multimillion dollar cases last year. The only thing that saved us is that frequency has leveled off, and we think that's because of some legal recognition of not addressing smaller cases.

We have put some sanity into the situation by making the company, and making our insurance company solvent. If the doctors' insurance company did not exist, then malpractice premiums would be where they are in Florida -- which is over $100,000 a year for physicians.

SENATOR CODEY: But they have decreased over the last couple of years, correct?

DR. MAURER: I think because of good management.

SENATOR CODEY: Okay. Thank you very much. Our next witnesses will be for the HEAL Coalition; Maureen Lopes, of New

Jersey Business and Industry; Melanie Willoughby, New Jersey Retail Merchants Association; and Mr. Paul Cooper, Prudential Insurance Company.

F R E D E R I C K A. W E S T P H A L: Good afternoon. We are not trying to outnumber you, but I think we wanted to have various viewpoints here.

Mr. Chairman and members of the Committee, we appreciate the opportunity to appear before you today. We certainly recognize the difficult task that you have before you. That is why we have a few members with us today.

SENATOR CODEY: Do you want to identify yourself, sir?

MR. WESTPHAL: Pardon?

SENATOR CODEY: Identify yourself.

MR. WESTPHAL: Sure, I'm sorry. I'm Fred Westphal, President of the New Jersey State Chamber of Commerce.

We come before you today as members of the HEAL Coalition. Let me explain what HEAL stands for. It is Help Establish Affordable Health Care Laws.

SENATOR CODEY: You took a name that sometimes has a different meaning. (laughter)

MR. WESTPHAL: Right.

The Coalition represents a group of small and large businesses, representing the employers -- I emphasize the employers -- who provide jobs for more than three million New Jerseyans.

Now, our message is a positive one: That all New Jersey residents should have access to health care. It is for this reason that we are able to endorse much -- and I emphasize much -- of what the Governor's Task Force on Health Care Costs recommended earlier this year.

However, we must reject the Commission's recommendation that the delivery of affordable health care makes necessary the imposition of employer taxes and penalties. First, to consider such a tax without knowing who

is utilizing the Uncompensated Care Trust Fund is tantamount, we feel, to writing a blank check before we know, really know, the magnitude and nature of the problem.

It is therefore our recommendation that a provision mandating an audit of the Fund should be included in any measure to extend the Fund's existence.

Second, enactment of the reform measures we will describe should serve to lessen -- I emphasize lessen -- the dependence on the Trust Fund, which was created to be a safety net for the uninsured.

Finally, we need to consider the extremely negative impact of another tax on our State's business community, and I want to emphasize especially small employers, as they struggle to survive in a fast-declining economy. It is certainly possible that enactment of a payroll tax and the so-called "play or pay" provision could lead to reductions in other employee benefits and even decreases in the labor force. We do not believe it is the responsibility of business to pick up the entire tab for affordable health care. We think that it is a societal problem for which government should assume a greater responsibility.

Permit me now to ask Hank Meisner of Prudential, a member company of the Health Insurance Association of America, to explain to you the reforms in the small group insurance market we are hoping to see translated into legislation and enacted as soon as possible.

SENATOR CODEY: Okay, sir. If you don't mind, why don't I just ask you a question on your testimony? On your testimony here, you stated that if we enact a payroll tax it could lead to reduction in some employee benefits. Is that correct?

MR. WESTPHAL: Yes. It is a possibility.

SENATOR CODEY: Could you not make the argument that if you don't do the payroll tax -- if you continue the present

system of 19% on a hospital bill in regard to those employers who now provide benefits, they would have to reduce their benefits because of that tax. If those businesses don't have the 19% tax on their hospital bills, but a payroll tax, they will save literally millions of dollars, and therefore would not have to reduce benefits.

MR. WESTPHAL: From a business standpoint, I don't see how we can start talking about an unlimited amount of money that's going to have to be taken from a payroll tax or something like that, until we really do the audit and find out what we really have to pay for it. Then I think -- we never say never -- we can certainly look at some of the--

SENATOR CODEY: No, but I'm saying, if you're an employer and you took that portion of your premium and you knocked off 19% of all of the hospital bills -- that portion -- and just paid the 144 -- dollars and cents -- you would be better off, and therefore you wouldn't be forced to reduce benefits.

MR. WESTPHAL: Mr. Chairman, let me just say that I've spent over 30 years in the business community in New Jersey. I don't think I have the wisdom to really understand and to tell small businesspeople or individual businesses how they should handle their costs and how they should meet that bottom line.

SENATOR CODEY: Well, I don't think that I was saying that. I was talking in regards to--

MR. WESTPHAL: Well, you're asking me to make a judgment on that.

SENATOR CODEY: No. I'm not making a judgment, I'm making--

MR. WESTPHAL: I think you have a problem right now. The uncompensated health care is a high cost right now. Two wrongs don't make a right, I don't think.

SENATOR CODEY: Right. But I'm talking about bottom line to an employer. If you eliminate the tax on his hospital

bill from his claim experience which drives his premiums, he would be better off financially with a payroll tax, if, in fact, you provide health insurance. Therefore, you wouldn't necessarily have to ask for copayments -- contributions -- from your employers, or a reduction in benefits.

MR. WESTPHAL: Now, that's possible.

SENATOR CODEY: That's all I'm saying. Okay, go ahead, sir.

H E N R Y E. M E I S N E R: Thank you, Senator.

In recent weeks the possibility of mandating employer paid health insurance has been discussed as one way to assure affordable and accessible health care. The HEAL Coalition opposes this concept as a quick fix solution which could have a devastating economic impact.

As a viable alternative to mandated health insurance, the HEAL Coalition has developed legislation which we believe will stabilize the cost of small group insurance, while improving the availability of insurance, thus making it appealing to the segment of the business community currently priced out of the insurance market -- the small employer.

Allow me briefly to describe the proposal:

Our bill makes it a condition of doing business in New Jersey that all small group insurance carriers, health maintenance organizations, and Blue Cross/Blue Shield must issue a health plan to any small employer. A "small employer" would be defined as: An employer who employs 25 or fewer full-time employees. One of the two plans that they must offer the employer is one basic, or bare bones, health care coverage without costly State mandated benefits. As you know, larger businesses which self-insure now operate without any required mandates.

In addition, the bill would eliminate preexisting conditions that exist when an individual changes jobs or coverage. All health carriers would be required to credit the

time that a person was subject to a preexisting condition exclusion under the previous plan. This means that an employee only has to satisfy a preexisting condition once, and would then be grandfathered, thereafter.

The HEAL proposal, in an effort to stabilize the widely fluctuating premium costs in the small group market, would limit annual rate increases for any group to 15% of the carrier's lowest rate for a group of similar characteristics.

In addition, the legislation would require that the premium rates charged for any group would not vary by more than 35% above or below the average premium rate for similar groups with similar coverage.

The legislation would provide for the establishment of affordable, small employer health benefit plans, including managed care features, to contain costs. Every small group carrier would be required to offer one of the approved plans, which would permit employers to make comparisons of premiums for identical products.

The costs and risk of covering high-risk groups and individuals would, under this proposal, be spread throughout the industry by means of a reinsurance mechanism. Participating in the reinsurance program would be voluntary, with small group carriers having the additional option of internalizing all risks and costs. Carriers electing to use the reinsurance facility would be subject to assessment of up to 4% of their small group market premiums to offset the facility's losses. A second assessment, if needed, would be assessed on all health carriers, up to 1% of premiums to cover the costs of the facility's losses. This assessment will be offset against their premium tax liability.

Let me make one thing clear about the reinsurance mechanism: It is not a JUA. This reinsurance program is designed to be attractive only to carriers with truly high-risk groups and individuals, with rates being set at one-and-a-half

times the rates established for classifications or groups with similar characteristics and coverage.

In summary, our small group reform will guarantee that small businesses have the availability of new business and renewal health coverage, while eliminating unnecessary preexisting conditions, and wide rate variations, with elimination of high rate individuals underwritten out of small group policies. This reform will allow businesses to shop on price and service based on equal products. It is our recommendation that these reforms be implemented as soon as possible, which would have a positive effect on the Uncompensated Care Trust Fund, without creating a financial burden on the taxpayers of the State.

I'll be glad to answer any questions, before we turn it over to the next speaker.

SENATOR CODEY: Yes. What would your bare bones contain?

MR. MEISNER: We have not designed the bare-bones policy yet, Senator. It would be designed by a Committee within the reinsurance facility, with the approval of the Insurance Commission.

SENATOR CODEY: At what cost would you be looking to--

MR. MEISNER: I think that depends upon what is decided to go into the policy.

SENATOR CODEY: I know that, but--

MR. MEISNER: We don't have a target dollar figure.

SENATOR CODEY: Okay. Thank you very much.

MR. MEISNER: The next person to speak will be Maureen Lopes, Vice President of Health Affairs for the New Jersey Business and Industry Association.

M A U R E E N E. L O P E S: Thank you. I'd like to speak today on the Uncompensated Care Trust Fund part of our recommendation.

As stated by our first speaker, any reform of the Uncompensated Care Trust Fund must begin with an audit to determine the characteristics of the patients whose care is paid for through the Trust Fund. This collection of demographic data should then be done on an ongoing basis to permit a periodic review of the patients' characteristics.

We would ask that the Legislature work with the Department of Health and the New Jersey Hospital Association to determine the most cost-effective way in which to make this data available for analysis in the future. I'm sure you're aware that there was this need two years ago when the Trust Fund renewed, and we still need that information.

Hospitals must also be given incentives to improve their bad debt collection. We suggest that each year that the Department of Health determine perspectively the amount of funding each hospital will receive from the Trust Fund -- not from the basic DRG rates -- for reimbursement of its charity care and bad debt. A hospital-specific funding level would be determined by a predictive model which would include such factors as: the bad debt ratio among peer hospitals; the unemployment rate in the hospitals' service areas; the hospitals' increase in total revenues; and patient income levels and insurance status. The data obtained from the completion of the audit will better define the key variables that we need to use.

Once its uncompensated care level was established on an annual basis, a hospital would be required to institute credit and collection procedures necessary to function within this level. As a safety net for any hospital which experiences a significant shortfall in uncompensated care funding -- during the year -- the Hospital Rate Setting Commission could undertake a full rate review.

In addition, we would strongly support the recommendation by the Governor's Commission that county and/or

State Medicaid workers be placed on-site at community health centers and hospitals serving large indigent populations to facilitate eligibility determinations.

Our final proposal in this area would expand reimbursement from the Uncompensated Care Fund to nonhospital providers. Specifically, we would support using up to 1% of the UCTF to fund pilot projects aimed at reducing the need for the Fund. One such project to encourage small business to provide health insurance has already been designed through a task force within the Department of Health. Melanie Willoughby and I served on that to provide business input.

Funding should, moreover, be provided for projects which form partnerships between hospitals which have a high percentage of emergency room primary care cases and local community health centers. We need to determine if the system as a whole can save money by encouraging people not to use the ER.

Now, I'd like to ask the HEAL cochair, Melanie Willoughby, President of the New Jersey Retail Merchants Association, to describe the final portion of our recommendations, which deal with Medicaid funding.

SENATOR CODEY: Okay. One of your recommendations was to increase the Fund by 1% to fund pilot programs. So, you're in favor of increasing the surcharge--

MS. LOPES: Yes.

SENATOR CODEY: --to fund those programs?

MS. LOPES: We think it could be very cost-effective, in the long run. It's an investment.

SENATOR CODEY: The other thing you mentioned about was setting specific dollar amounts that a hospital would be reimbursed for. What would happen if after 10 months the hospital had depleted their allowed set of moneys? Would they turn patients away?

MS. LOPES: No. Within the regulations now being proposed within the Department of Health, hospitals, in general, that were having trouble living within the rates during the year could always go to the Hospital Rate Setting Commission for a full rate review. It would open up the total books of the hospital. We're suggesting that uncompensated care funding might be one of those trigger points. And I would think most hospitals would know six months into the year that it looks like in 10 months, they're going to be in trouble. So they would have that as a safety net; that there's a place that they can go to look at their total funding mechanism and the difficulty they're having living within uncompensated care--

SENATOR CODEY: Okay. Thank you.

MS. LOPES: --if there were unemployment increases -- those sorts of things.

M E L A N I E L. W I L L O U G H B Y: The third recommendation deals with Medicaid reform. Even with the most optimistic expansion of coverage by the private insurance market, some people will remain uninsured. Some are part-time workers and their dependents who cannot afford to purchase their own health insurance. Others are single and unemployed. And there are always some who are temporarily without coverage.

We believe that expanding and revising portions of our Medicaid system will result in more of the State's low-income uninsureds receiving health coverage, without needing to tap the Uncompensated Care Trust Fund.

The first provision of HEAL's proposed Medicaid reform legislation would -- as the Governor's Commission suggested, and as Commissioner Dunston recommended here today -- extend the Medicaid to include all persons who fall below the poverty level, irrespective of age, disability, family, or employment status.

Most of New Jersey's poor and near poor who are not covered by Medicaid must now rely on the Uncompensated Care

Trust Fund if they become ill. If they were to be brought under the Medicaid umbrella, matching funds would be available also.

We also propose that an HMO-type program should be established to provide medical care to individuals within the Medicaid program. With financial support from both State and Federal governments, such a program would provide recipients with quality care through a primary care provider, rather than relying on the more expensive emergency room or inpatient care treatment.

A Medicaid buy-in program is another component of the HEAL proposal. Under this concept, people with incomes of less than 50% above the poverty level -- and with limited assets -- would be permitted to buy coverage for a limited set of nonhospital primary and preventive services at a premium cost, based on their ability to pay.

This program would grant the near-poor access to the care they now must forego. It would fill in, in front of private plans, for near-poor persons who also have private coverage, and it would avoid costly government substitution of public coverage for private coverage. As a temporary measure, this type of buy-in program could also be extended below the poverty level if fiscal realities in New Jersey make impractical the provision of a complete range of Medicaid services.

Our final suggestion in this area is the establishment of a Medicaid buy-out program where the near and working poor would be encouraged to use employment-based coverage and the State would pay a portion of the worker's share of this private coverage. Contributions toward premiums, deductibles, and copayments would be included as they were in the recently enacted Connecticut Medicaid law.

In closing, we believe that Medicaid reforms present an important opportunity for the public sector to meet the

needs of the uninsured. Funding from Medicaid, coupled with private-sector reforms, are elements key to a comprehensive resolution of our health care crisis.

We at the HEAL Coalition -- and you see only a small portion of us represented here today -- really believe that by tying together small business reforms, comprehensive reform of Medicaid, allowing more people to buy in, as well as a preferred provider organization -- setting those up in the State, which is a bill that has already been introduced by Senator Jackman-- When you couple that with reform of the Uncompensated Care Trust Fund, we feel that we need to reform the system before we determine any additional alternative funding sources -- as some others have testified here today -- that they think are required. Thank you.

SENATOR CODEY: I don't know who would want to answer it, but how is HEAL funded?

MS. WILLOUGHBY: HEAL is funded by contributions from all of the representatives that are part of the Coalition. We have seven members--

SENATOR CODEY: Does the Retail Merchants Association fund it?

MS. WILLOUGHBY: Yes. The New Jersey Retail Merchants Association, the New Jersey Food Council, the New Jersey Business and Industry Association, the New Jersey Chamber of Commerce, the New Jersey Restaurant Association, the Health Insurance Association of America, and the National Federation of Independent Business, all make up--

SENATOR CODEY: That was pretty good. (laughter)

MS. WILLOUGHBY: --the Coalition. Then we have individual members who are on the Coalition as well, who are corporations that have decided that they would like to join. We are also seeking other organizations which would like to participate in the HEAL Coalition, that believe in pushing the proposal that we put before you today. And each organization contributes, based on their ability to pay.

SENATOR CODEY: I wouldn't want to define that. (laughter) Okay. Thank you very much.

MR. WESTPHAL: Thank you.

MR. MEISNER: Thank you.

SENATOR CODEY: Our next witness will be Mr. James Morford, Vice President of Governmental Relations for the New Jersey State Chamber of Commerce.

J A M E S C. M O R F O R D: Thank you, Mr. Chairman. With me is my associate, Bill Healey, who has been an active participant in the HEAL Coalition, on behalf of the State Chamber.

Mr. Chairman, and Senator McManimon, the New Jersey State Chamber of Commerce is pleased to offer comments on the recently released Report of the Governor's Commission on Health Care Costs. The State Chamber, along with its affiliated local and regional chambers of commerce, represents more than 45,000 businesses throughout our State.

We commend the Governor for creating the Commission, and the members of the Commission and the staff for their hard work.

As you know, the New Jersey State Chamber of Commerce has expressed very deep reservations about some of the specific points in the Report of the Governor's Commission, specifically the proposed payroll tax -- which we have been fibbingly told is really good for us -- and the health insurance mandates or penalties, commonly known as "pay or play."

The State Chamber stands for cost controls anchored by managed care and small group policy reforms, with all players participating: business, labor, government, hospitals, doctors, insurance companies -- all sharing the problem, and all having a stake in the solutions.

The debate on the issue of health care delivery is one that has been driven by the spectra of rapidly rising costs: costs that for the most part have been absorbed by the business

community. Some pressure is also being felt by our State's largest labor unions, particularly those which cover the costs for their members. These particular labor organizations share a common concern with the majority of businesses that bear the costs for providing health insurance for their employees.

At the present, nine out of 10 full-time workers in the State of New Jersey are covered by health insurance. Most businesses that don't provide health insurance for their employees are small businesses, and they have made that decision because of the costs.

Mandated health insurance coverage will serve to drive more small business owners to close their doors. The result could very likely be an increase in unemployment and additional drains on the Uncompensated Care Trust Fund.

The State Chamber is deeply concerned over the proposal of the Governor's Commission to impose a payroll tax. At the very least, such a proposal is premature. Without instituting needed reforms in our health care delivery system first, the imposition of a payroll tax would clearly be a case of putting the cart before the horse.

We urge that the Uncompensated Care Trust Fund be extended for 18 months under its present -- albeit unsatisfactory -- funding system, and -- let me stress -- all bad, unsatisfactory, present funding system. We don't want that system to continue indefinitely, but the extension must be accompanied by reforms.

When we can evaluate or even estimate the impact of the reforms we propose, then, and only then, do we feel it will be appropriate to consider funding alternatives to the present system.

While there are those who, with great vigor and emotion, advocate the opening of yet another business tax vein, we must resist with equal vigor a proposal which would use the payroll tax to fund not only a renewed Uncompensated Care Trust

Fund, but add additional programs. Those additional entitlements, including some currently funded by State general revenues, are listed as goals in the Governor's Commission Report.

These programs, while laudable in intent, will cost a great deal of money. By conservative estimates, the annual price tag would be more than $350 million a year on top of what is to be paid currently, and perspectively, for the Uncompensated Care Trust Fund. And that's just the first year.

Some very well-intentioned people urge you to enact the payroll tax now and penalize those recalcitrant business owners who refuse to provide health insurance. But, once this new revenue source is open and without prior reform of the system, how do we stem the flow to meet ever-increasing demands? Where's the tourniquet?

We find nothing in the Commission's Report -- or in history -- to give us any confidence that replacing the hospital surcharge with a new tax on business will be kept at this initial level. Indeed, history will document that we can anticipate only "increases."

Again, put reforms in place first; then let's talk about alternatives to the funding mechanisms.

The Legislature itself, Mr. Chairman, has a critical role to play in setting the tone for health care cost containment. One of the primary factors in the rapidly expanding cost of health insurance is mandated benefits. They represent upwards of 10% of the premium dollar. Yet, even as we meet here today to consider the dire condition of our State's health care delivery system, there are at least six active bills under consideration in the Legislature that would impose new mandated coverages. Of course, each proposed mandate is a worthy cause, but each would add to the cost of providing health insurance.

We agree with the public policy that no individual should be denied access to health care because he or she cannot demonstrate an ability to pay. It's a policy that is beneficial to all New Jerseyans. However, the State of New Jersey should not shy away from its own stake in this policy. Instead of trying to pass on more of its responsibility to provide for its citizens through a new business tax, the State should commit a greater portion of its general revenues -- its more than $12 billion budget -- to fund this commitment.

At present, we feel the State has made the promise, then handed the business community the pledge card through increased costs, more mandated coverages, and now a payroll tax, with added penalties for those who do not provide health insurance.

The New Jersey State Chamber of Commerce thanks you, Mr. Chairman, and members of the Committee, for the opportunity to offer comment on the Report of the Governor's Commission on Health Care Costs.

SENATOR CODEY: Thank you very much, Mr. Morford. Our next witness is Mr. Ed Peloquin, Executive Director of the Central Jersey Health Planning Council. Mr. Peloquin?

E D W A R D J. P E L O Q U I N: Thank you, Senator Codey, and members of the Committee. As you all noticed, handed out to you was a very bright gold color description of, "Local Health Planning Agencies Make a Difference." The reason I chose the color is that throughout the last six months of the deliberation of the Governor's Commission on Health Care Costs, the deadline of December 31, 1990 kept continuously being raised as the expiration of the Uncompensated Care Trust Fund.

I'd like to remind the Committee that there is another deadline of December 31, 1990. That is the last day of State funding for local health planning. Now, the fact of the matter is, when the budget was struck this summer, we were led to believe that there would be a six-month extension for local

health planning, so that the Governor's Commission on Health Care Costs -- in examining all of the roles of the various apparatuses for regulation and planning and local input -- could come to a decision. The Report came out on October 1, and for the sixth time in the last four years, concluded local health planning and consumer provider input at the local level were essential and necessary.

What that yellow sheet describes is the three extensive hearings in 1986, the two special studies in '87 and '88 -- one by the Attorney General, the other by a blue-ribbon commission -- and now the Governor's Commission Report, that all say the same thing: Local health planning makes a difference. It is common sense, and economic sense, to keep it. Yet, at this point in time-- I just lost my secretary, who resigned. She said, "I can't wait any longer. We don't know if we are going to be able to pay our bills on January 1."

We do have a letter from Commissioner Dunston, who indicates that what we are suggesting -- in the form of a transition -- under the circumstances, would be appropriate. We're asking for at least a six-month transition and an opportunity to work with the legislators, with the Department of Health, and with the Governor's Office, to design the new local health planning program. And that is where my comments are going to concentrate on for the next couple of moments. However, if we do not do that, we face the loss of $80,000 in assets that will be sold at 10 cents to the dollar, in dissolution. And we face the loss of a mechanism -- the system of about 800 volunteers, who month to month meet on these various programs. The Certificate of Need-- We tend to put the whole system into quite a bit of disarray.

One of the comments that was made to me is that while some of the reform and regulatory aspects such as the moratorium on Certificate of Need applications-- There won't be any applications to review. Wrong. The moratorium as

recommended by the Governor's Commission covers approximately 10% to 12% of the application volume, and deals mostly with the hospital major expenditures.

The Certificate of Need program covers everything from nursing homes to ambulatory centers, to the home health agencies, to a variety of freestanding and closed-base services. They go through the process, including things such as associated retarded children services and mental health services, that have to have some local input to determine that they are the best and most affordable in the area. That will still go on.

The whole system requires a major legislative enactment that's not envisioned by the report, and that's about 85% of the work load that goes on, day in and day out. I already have the Certificate of Need filed for January. I know what the work load is, already.

I think it is something that this Committee really needs to pay attention to. We urge the Governor, and the Commissioner of Health, to move expeditiously on the funding side so that we can transition in an orderly manner.

Now, let me bring out two or three other points related to the LABs -- the Local Advisory Boards. I'd like to suggest the following considerations be made when these are established:

One, I think the consideration most important is as follows: The composition of the governing body of each corporation shall specify, under the terms of an agreement with the corporation, the awarding of a grant, the mock-up -- the grouping of that corporation -- its body. The Commissioner has to approve the corporation with each geographical area that is decided. And there should be at least three general geographical areas, if not more.

What I am referencing when I speak here, is the law passed in 1987, called Chapter 118, P.L. 1987, which

established a statewide local health planning program. And what I am submitting to you today is that that very law -- sponsored by Senator McManimon -- is a law that can be modified very quickly, if at all. As a matter of fact, the legal reading of it is: "The Commissioner can enact, right now, the Local Advisory Board reforms, with this law in place." They can enact it as soon as January 1, if they wish. Common sense says that you can't decide all of the geographic areas until you go through the process. But it could be enacted by July 1. That's why we said a six-month transition.

It gives the Commissioner the authority in the composition, and the authority in the expertise, that is needed, and it also will be able to spell out what subject matter these Local Advisory Boards speak on. But it does not limit the advice those boards provide. It does not limit the free flow of information exchange of the consumers, and generally we support the Local Advisory Board concept and the proposed Governor's Commission's future recommendations.

We would like to work on that with the Committee, and with others, as we go through the process of implementing the Governor's Commission Report.

I would like to go back for just a moment, to a couple of aspects of the Governor's Commission Report that are, I think, not spoken to, in terms of what local health planning ought to be doing in the future under the Local Advisory Board. There are two areas that are in need of desperate change. And I think I will label this as the "need to establish a certificate of affordability," rather than a Certificate of Need.

The Certificate of Need and affordability combined are factors that are hinted at in the Report. They are never really pulled together. It's one thing to have something presented to you, and to be shown dramatically that we need a $30 million renovation project at a particular hospital, and to

have the community say from a quality of care standpoint and from the improvements in that facility, and the fact that no new beds or no new services are being added, that this is needed for the quality of the community's health care.

If we ask the other question though, will the community pay for it, and can they afford it, that's not asking the current Certificate of Need process. And if we ask that question along with the need, then we may have a different answer as we go through the Certificate of Need or the health planning program, and I submit to you, that we had elements in the regulatory reform that are bringing those two aspects together. I would strongly support urgent and immediate implementations of a State health planning process and the Local Advisory Board process, and move that forward, and look towards bringing those two questions together in some rational manner.

I think we will get a lot better decisions and a lot more affordable health care. But at the same time, what you are going to be paying for you'll know will actually be needed. Right now, we're kind of split. It makes a difference. I won't go into citations as to how this is working or not working, but I can, if necessary, at another time.

The other thing that we are not looking at very grandly or with very much depth that we did look at a few years ago, is access to health care. In this case, access is uncompensated care. Are the uncompensated care dollars being spent really providing access to the poor, the disenfranchised, the people who can't afford care? And if so, in what numbers, in what locations, and how? We can make judgments after the audit is completed about this. But after the audit is completed, and decisions are made, we do not have a monitoring process in place. We don't have a process of monitors day-to-day if, indeed, things change -- one year, six months after another.

When we have pledges, they come in to us as follows: Any given night that we review Certificate of Need applications, and we review them month in and month out, Senators. We review these day in and day out in the analysis of the committees. Any given night, I could have 12 or 14 applicants -- which is a horrendously large number for any one agency, but that's the volume we have been running -- stand before us, and on that night there is no access problem anywhere in our area. None. Two days later I will get a call, and there is an access problem.

It's amazing what's promised and what's delivered. No one really knows. We can presume, for the large part, the hospitals and the nursing homes are delivering access up to their means. But we still have an uneasy feeling because of these calls -- these communications -- that things are not going exactly as they should, and maybe there is some data -- some numbers that can be looked at on a day-to-day basis to prevent a catastrophic situation from occurring.

On the other side, there is one other role that public information and education have to play dramatically in the new local health planning process. Education of the public heretofore has been fragmented and disjointed. We've proven at the Central Jersey Health Planning Council that a statewide education program is working, and, indeed, it's working under, again, the auspices of this Legislature.

What we've linked is health services availability and information to the Medicare system. As many of you know, we started operating the new Medicare, long-term care telephone toll-free information service just a couple of months ago. It's an 800 number: 1-800-648-MTIS, to be exact. Your offices have the number now. And we're able to do such things in that number as identify specifically who accepts Medicare assignment, and where. We will be able to do such things in the future as locate where the nursing homes are that have availability of services and programs.

We are able to do this because we linked the Medicare data, which is the cost side, with the access side of where services are, through one statewide phone system. That's education that can be built on the Local Advisory Boards.

The last thing I want to say in terms of the Certificate of Need and planning activity is, in that activity we will need a safety valve. The appeals process has been removed by recommendation of the Governor's Commission, and I agree with that removal at this point in time. There's a safety valve in there. If the plan is not right, we're supposed to be able to turn back to the planning process in a short amount of time, and correct the problem, then come back and seek a better solution. If the plan is rigid -- as plans in the past have been, whereas they've gone three, four, or five years without change -- we are not going to have the safety valve. We're going to have to see the appeals process come back into play. I don't particularly care for the appeals process. It involves litigation, heavy expense, and doesn't really serve the community well, except in those cases where we had one decision opposite what the Commissioners granted us, in protection of the community good.

Now, the last comments I'm going to make, of a more personal nature and they cover the spectrum of the Governor's Commission Report-- The first thing is, I want to basically compliment the Governor and the legislators on-- I want to urge the legislators to continue -- to keep the employers and the employees together. Here we had a Commission for the first time in history, that had the cochairs of the business community and the labor community with a neutral, in this sense, to the Governor's Office, pulling together on this Report.

Now we see them split, out here in the audience. My point is, I think there's really a lot more closeness between the two points than what you see right now under the timetable

in which they are working. The legislators must keep these people together until we get the reform and the resolution of the financing in place. This is the healthiest thing I've seen happening in years of looking at this country; when the employers and employees get together.

I happened to do some work in Connecticut -- I know their new system very well -- and we pulled the employers and employees together up there, three years ago. We've made some tremendous reforms when filing on a day-to-day basis. Both realize eventually both of the people are going to be patients, both of them are paying for it, and really their points of view come to a common ground. This Governor's Commission follow-up has got to be that way.

Some quick comments on the Report itself:

SENATOR CODEY: Mr. Peloquin, you've taken about 15 to 20 minutes already. If you could rap up--

MR. PELOQUIN: All right. I've covered 17 years in this State--

SENATOR CODEY: I understand that--

MR. PELOQUIN: I have five -- two minutes.

SENATOR CODEY: --but I'm trying to get through a whole agenda--

MR. PELOQUIN: I understand.

SENATOR CODEY: --and trying to be fair to everyone.

MR. PELOQUIN: I have no problem with that.

The four comments I had to make are as follows: In terms of insurance reform, I am suggesting that whatever is set up as a bare-bones package be a minimum standard package where no insurance company can offer anything lower in the State of New Jersey. If we don't do that, we've got serious problems. I could elaborate, but not today.

Secondly, annual rate settings for all of the hospitals. Totally support that concept; bring all of the hospitals on-line at the same time.

Third is managed care. Definitely, managed care, particularly in a Medicaid community, is an absolute asset and something that will do a lot of good.

Malpractice: One area that has not been explored is the use of mediation and arbitration as a form of malpractice reform. It was tried about four years ago in this State. It was not receptive at that time, because we would lose the emotion of the jury trial, rather the logic of real data in terms of arbitration and mediation can offer. I think it is time to look at that again. There are major successes in Michigan, and some other parts of the country with that, at very low cost.

The last thing, prevention and wellness; health services at the local school level. The local school health services are lacking -- need more funding, and the community neighborhood health centers also need more services and more funding. Those five aspects, from the respect of health planning, are the five pieces you had asked about earlier in the day on priorities-- I would suggest that those are the five priority areas that should be looked at when we go into the 1990s.

Thank you for your time. Sorry I overextended the time. I wasn't given a limit. I was trying to stay within a reasonable frame.

SENATOR CODEY: Okay. Thank you very much, Mr. Peloquin. We're going to break for lunch, and reconvene at 2:00. Thank you.

(RECESS)

AFTER RECESS:

SENATOR CODEY: I'd like to reconvene, please. Our first witness this afternoon is Mr. Al Evanoff, Executive Vice President of the United Senior Alliance.

A L E X A N D E R E V A N O F F: I have to get myself together. I have the Medical Society's testimony here.

SENATOR CODEY: I don't think you'd agree with them on some things.

MR. EVANOFF: No, no, no.

Senator Codey, and other Committee members, my name is Al Evanoff, Executive Vice President, United Senior Alliance. The Senior Alliance is a New Jersey grass roots organization of seniors' clubs and individual members concerned with senior issues. We are interested in equality, dignity, and justice for all seniors.

On behalf of the Alliance, I want to thank you for the opportunity to present our views on some of the important health care matters for all New Jersey residents.

We believe that health care is a special service, or social service that should not be the property of any small group interested only in profit. It should be the right of every resident of New Jersey to have the best health care available in the State and in the country.

Governor Florio deserves to be commended for the speed with which he established the Commission to examine the health care problems in New Jersey. It is to the credit of the Governor's Commission to recognize that our country faces a health care crisis, and that a Federal system of health care is necessary.

Since such a system is not being developed, the Report properly makes recommendations to improve access to health care in our State. However, the Commission's 92 recommendations do not go far enough. And although the Commission participants should be commended for the Report, they should have proposed a New Jersey universal single-payer program for all New Jerseyans.

It's not our intention to discuss all 92 recommendations in the Commission Report. However, there are a number of items that we wish to bring to your special

attention. Commission recommendation No. 55, on page 24 of the Report, is of special interest to all seniors and disabled in New Jersey. The Report calls for a halt to all balanced billing. It should be understood that Medicare is a social contract entered into in 1965 between the government and seniors.

Seniors and disabled should be assured the right to health benefits upon paying their premiums, without any extra out-of-pocket costs. The extra or balanced billing that doctors charge seniors and disabled amounted to over $129 million this past year. Persons living on fixed incomes cannot afford to carry this extra financial burden. These large out-of-pocket costs are forcing seniors and disabled to avoid going to doctors until the illness requires an emergency room visit and admission to a hospital bed, which multiplies the cost of health care. It also impacts on the Uncompensated Care Trust Fund, since we no longer enjoy a Medicaid waiver.

Elimination of this $129 million of balanced billing would help many union and management health plans that pay retired workers medical benefits. It would also save the State health plan thousands of dollars, because retirees of the State with 25 years of service receive health coverage. The New Jersey Medical Society is misleading the public and State legislators by referring to the doctors fine record in the treatment of seniors and disabled at Medicare allowance.

In the first place, less than 25% of the doctors in New Jersey are participating doctors -- taking the Medicare fee for all their patients.

In the second place, a newspaper ad for the New Jersey Medical Society says, "70% of all claims are at the Medicare rate." But the facts show that if you exclude laboratory and equipment claims, and just consider doctors' treatment claims, less than 50% of the claims aren't Medicare fee.

The third distortion is the Medical Society's claim that the Federal government is limiting doctors to balanced billing. The fact is, Congress did pass legislation that limited the doctors' right to balanced billing to 25% in '91, and 20% in '92, and 15% in '93, but it never cut out balanced billing. During these past budget discussions, the Medical Society, persuaded Congress to permit doctors to extra bill as much as 40% above the Medicare allowance in '91.

Seniors in New Jersey average about $14,600 annually, while doctors have an income of over $100,000 annually. It would seem -- as the Commission Report indicates -- balanced billing should be outlawed in our State.

There is a myth that circulates, that the majority of seniors and disabled carry Medigap insurance, which pays their bills when doctors balance bill. This is a myth. Insurance policies for which seniors pay extra money do not cover balanced billing, but merely provide the 20% due doctors after Medicare pays 80% -- after the approved fee. The payment for balanced billing comes out of the pockets of seniors.

Both the Assembly and the Senate have bills before them that would eliminate balanced billing. Assemblypersons Stephanie Bush and James McGreevey have introduced A-3042. Senator Carmen Orechio has introduced S-1975. We would urge this Committee to bring these bills up for a vote. The Governor is on record as being in favor of this legislation and is ready to sign this into law. This legislation on balanced billing is one of the important steps that our State can take to control the rising cost of health care.

Seniors recognize that health care is intergenerational, and that it is necessary to provide care to both young and old if we desire to have a healthy and productive society. We support, and would like to see the immediate introduction of bills to carry out the recommendations of the Commission that deal with preventive

health care, such as the expansion of Medicaid for mothers and infants. We believe it is foolish and unsound to withhold dollars for preventive care, and then spend tenfold for critical care for the same individual.

We especially support the recommendations that propose to improve the rate-setting process, the Certificate of Need -- by providing providers process, and to bring the community into the process of planning the health needs of our State.

As to the rate setting process, we urge that any legislation should require the Rate Setting Commission to examine all operations of the hospital, and not permit any institution to spin off what may be considered profitable, and expect rates to be set on only half of the necessary information.

In any legislation regarding Certificate of Need, we must be concerned with the unnecessary overexpansion of costly high technology equipment. We support the Commission's recommendation to bring all providers under the requirement of the Certificate of Need process. This is one of the very important requirements for beginning to control health care costs.

We believe health care should be the concern of every community, and we support the recommendation that urges that the community boards be continued and a health plan for the State should be also devised. The recommendation to replace the Uncompensated Care Trust Fund is a key in this Report. When New Jersey established its DRGs and Uncompensated Care Trust Fund, we were responding to a critical need. The problems of uninsured have grown far beyond what any of us might have imagined or anticipated.

The Uncompensated Care Trust Fund is costing all New Jersey residents, directly and indirectly, hundreds of dollars, for a total of close to a million dollars. We now pay through a system of surcharges on every hospital bill, which translates

to higher insurance premiums, which, in turn, causes persons and companies to drop health coverage. The total of New Jersey uninsured is approaching one million persons, and continues to grow. The recommendation to substitute 1% of salary, or a maximum of $144, as a premium payment from all employers on behalf of their employees for the present surcharge on hospital bills, seems fair to us. This premium would not cost any employer more money, and they would save money in the long run.

All of the employers who have health coverage, at present, must be required to maintain their present coverage. Those employers who have enjoyed a free ride, and an unfair advantage in business by not providing health insurance, are now being asked to pay $1000 per employee. This sum should be large enough so as to compel employers to provide health coverage, rather than to continue to have an unfair advantage over those employers who provide coverage.

There may be something to be said about having employers who enjoy a free ride make a fixed down payment for the years in which they enjoyed the health care free period, while others had to pay for their employees' hospital bills. The appeal that small employers cannot afford to pay the 1% plus $1000, has to be placed on the same level as those who said they cannot afford Workers' Compensation, or Social Security, and to this day cry that they cannot afford the minimum wage. This must be seen as a business expense.

Those who want to refer to this proposal as increased taxes should face the truth. We now pay out of this money through a surplus charge on the sick, and shifting these costs through a broad-based method of payment is not only fair, but an intelligent solution. The importance of this Commission's Report and its recommendations must be taken up by the legislators, and should be enacted into law without delay.

Delay not only causes increased expenditures, but untold hardships on mothers, infants, and the uninsured, whose

lives are disrupted by their concern for how to confront their next medical emergency, and seniors and the disabled who have asked the legislators these past two years to limit the burden of millions of dollars off their backs.

We now have our neighbor, the State of Pennsylvania, with a no balanced billing law in effect, and we feel that our time has come. New Jersey must act on Medicare assignment legislation and present it to the Governor for signature.

I thank you for permitting me the opportunity to speak to you, and present these remarks.

SENATOR CODEY: Thank you very much, Mr. Evanoff. Our next witness is Mr. Leighton Holness, Senior Attorney for Legal Services of New Jersey. I ask that we keep our remarks to five minutes, so that we can get through the remaining amount of people who wish to testify. Go ahead, sir.

L E I G H T O N A. H O L N E S S, ESQ.: Good afternoon.

Legal Services of New Jersey welcomes the recommendations of the Report of the Governor's Commission on Health Care Cost to:

1) expand public and private health insurance;

2) emphasize primary and preventive care in all health plans;

3) continue to provide for the acute care and outpatient costs of all those who remain uninsured and unable to afford to pay their hospital bills; and

4) develop a State health plan with the force and effect of State law, that would drive the regulatory process.

Legal Services of New Jersey agrees with the underlying premise of the recommendations; that it is simply farsighted to provide wider health insurance coverage and emphasize preventive care, rather than to treat the uninsured poor in expensive acute care settings both for illnesses which could have been treated in a more appropriate setting, and for illnesses which could have been avoided if preventive care had been available.

We are concerned that if a rational and comprehensive approach to health care is avoided or postponed, eventually those elements of the health care system which do serve the poor, especially the Uncompensated Care Trust Fund, will be restricted. As advocates for the poor in New Jersey, please allow us to emphasize that any curtailment of uncompensated care would be an unmitigated disaster for poor people.

As the Governor's Commission reported, the only acceptable way to contain the costs of uncompensated care is by decreasing reliance on the Fund by increasing the number of people with insurance.

The most cost-effective form of insurance is Medicaid, because it is matched dollar for dollar by the Federal government. The Commission has recommended that legislation should be enacted which expands the Medicaid eligibility groups to include all optional groups for which Federal financial participation is available. This was also the most unanimous recommendation of those who appeared before the Commission. Once again, Legal Services of New Jersey urges that the State take every opportunity to provide health insurance for poor people on these very favorable terms.

However, this Committee would perform a great service to the poor of this State if it merely facilitated the implementation of Medicaid coverage for all those who are mandatorily, not optionally covered under Federal law and yet do not receive the coverage in New Jersey to which they are entitled. The Omnibus Budget Reconciliation Act of 1989 mandated that all states, beginning April 1, 1990, cover children up to age six at 133% of the Federal poverty level. New Jersey has not yet done so, and apparently there are no plans to provide Medicaid to children who would qualify under this standard before April 1, 1991.

The National Governors Association is unaware of any other state which is not already providing Medicaid coverage

for these children. I've provided you with a copy of a survey taken by the Children Defense Fund in Washington. Of all 50 states, the only one which has not done it at this point, is New Jersey.

It appears that New Jersey is attempting to take advantage of a provision in the amendments to the Federal Medicaid statute which allows a state not to implement them until April 1, 1991, if the amendments also require state legislation. Although we have been informed that the Division of Medical Assistance and Health Services has relied on an informal written opinion of the Attorney General to the contrary, no new State legislation is required to implement the expanded eligibility provisions of the Federal Medicaid statute.

The New Jersey Medical Assistance and Health Services Act specifically requires that the State Department of Human Services: "Shall provide medical assistance on behalf of all recipients of categorical assistance and such other mandatory groups as are mandatory under Federal laws, and rules, and regulations as they now are, or as they may be hereafter amended, in order to obtain Federal matching funds for such purposes." See Section 30:4D-7b.

The sooner the Department implements these expansions of Federal Medicaid eligibility benefiting thousands of preschoolers in the State, the sooner many of them will no longer have to rely on the Uncompensated Care Trust Fund. With a stroke of his pen, the Commissioner could thereby contribute to a reduction in the surcharge on each hospital bill and provide more Federal dollars for New Jersey's health care system.

The legal interpretation relied on by the State could continue to cause New Jersey to lose Federal dollars into the next century. Medicaid amendments enacted as part of the recent budget agreement extend mandatory Medicaid coverage to

children at 100% of the Federal poverty level on a year-by-year basis, so that by 2001 all children 18 and under who are poor, would be covered.

However, this amendment also provides that, although it is effective as of April 1, 1991, states need not begin implementation until April 1992 if state legislation is required. It would be tragic for the children of this State, and expensive for hospital bill payers, if New Jersey allowed itself to fall one year or more behind other states in providing mandated Medicaid benefits for poor children.

It would be ironic if New Jersey failed to take advantage not only of optional, but also of mandated matched benefits provided by a Federal government which has been criticized for not taking the lead in addressing the national health care cost crisis. This fear is not baseless.

According to the Health Care Financing Administration, in 1989 New Jersey's participation rate in Medicaid's Early and Periodic Screening Diagnostic and Treatment Services Program -- which was significantly improved by the Omnibus Budget Reconciliation Act of 1989, and which is the most comprehensive health care service for children in the nation -- was only 11%. Only five states had lower participation rates. North Carolina's participation rate was 54%. Arizona's participation rate was 96%.

Legal Services of New Jersey urges this Committee to remember that there is much that can be done for the health needs of the poor in this State, even within the existing patchwork of programs. Cost-effectiveness must be your guide. Therefore, shortsighted solutions which avoid a comprehensive approach to health care for the future, or which presently pass up the offer of matching Federal dollars, should be rejected, because in the not too long-run, these supposed solutions will be the most expensive.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Holness. Our next witness is Dr. Mark Olesnicky, President of the Essex County Medical Society.

M A R K T. O L E S N I C K Y, M.D.: Senator Codey, and members of the Committee, I thank you very much for this opportunity to appear before you.

One of the last speakers spoke about the malpractice premiums in the State of New Jersey, and from my standpoint I would like to clarify one issue: Only certain levels of premiums have gone down; namely, anesthesiology, orthopedics, and gynecology. On the other hand, obstetrics has not gone down, and that has caused the major problem, because the number of our obstetricians is decreasing. I, myself, who am in primary care and have never been sued, my premiums have not gone down. I believe that it is possible that the total premiums in the State have gone down, but they have not really been across-the-board.

I am President of the Essex County Medical Society. We have reviewed the Commission's Report and would like to congratulate them on tackling an almost impossible task and providing a yeoman's report. We find many areas of agreement. Other recommendations concern us because they urge unnecessary changes, or the establishment of new bureaucracies, which will add to the cost of medicine and show lack of sound medical judgment, in the administrative sense.

On representation, we were most pleased to learn Governor Florio's recent remarks during which he said, "Policy decisions will be made on a collegial basis with participation from leaders from all parts of our community." His readiness to listen to constructive alternate proposals which will be negotiated, modified, and reviewed, is to be applauded.

SENATOR CODEY: Yes, but he was only talking about the ones that he already did.

DR. OLESNICKY: Okay. (laughter)

Physicians felt left out in the development of this Commission's Report because none of our organizations were requested to participate or asked for representation. We also noted that there is no recommendation for physician representation on the State Health Planning Board, the board which would be the successor to SHCC. We respectfully request such representation through the Medical Society of New Jersey.

On Medicaid emergency room care, for instance, we agree that Medicaid should be expanded and nonemergent, episodic care for Medicaid recipients should be taken out of the emergency room and handled in private physicians' offices. Better, continuous family care will benefit the patient. Private physicians should be given incentives to handle this care at about one-third of the cost of the ER bill to Medicaid.

The last time the Garden State Health Plan HMO made a presentation to our County Medical Society, they turned physicians off by having M.D.s under risk for hospitalization. Under such a system -- which I will not elaborate on -- a doctor could work all year, and if he had many sick, hospitalized patients, he would lose all HMO income and still owe Medicaid. We hope the Commission has a better plan and is able to define succinctly what it calls "managed care."

Certificate of Need philosophy was formulated to keep large health facilities from performing expensive, duplicative work. We see no need to extend Certificate of Need legislation to solo practitioners' offices, as your recommendations state.

On rebundling, we feel that physician services provided in hospitals should be on a fee-for-service basis in line with TEFRA regulations. Medical care provided by physicians and not hospitals should be reimbursed as such, thus eliminating added administrative and other inherent hospital costs.

On the subject of voluntary versus mandatory assignment, physicians fail to grasp why they should be one

only discipline singled out and prohibited from making contracts with senior citizens who desire such contracts. We can't see the reasonableness of a State demanding compliance to a Federal program not mandated in the Federal law. Congress failed to fund the Medicare program sufficiently and many senior citizens have to supplement Medicare's allowance for physicians' fees.

The physicians whom I represent have long been aware of the immense burden and occasionally devastating consequences of health care economics as they relate to our elderly. We have addressed the issue, and as early as 1982 we voluntarily froze our fees.

In 1983, Congress, inspired by our good will, continued the freeze. Our current medical fees which reflect decreases through Gramm-Rudman, have not kept pace with the increased cost of practicing medicine. Even so, many physicians in the State do accept assignment on Medicare and other patients, when need is demonstrated. It has been demonstrated that on the average, New Jersey doctors provide $12,000 of care without reimbursement every year.

To make our elderly patients aware of our concern for them, we have a very active senior citizens medical courtesy program in every county of the State. The senior citizens meet regularly to review applications for those in need, and we have many physicians who have agreed to accept assignment on those patients. A Senior Citizens Screening Committee -- and not the doctors -- determines who is in need. We favor a voluntary approach.

Medicare fees have been set in 1984, and many of our doctors accept Medicare payment as payment in full. Physicians who have elected not to accept Medicare assignments are definitely not free to charge whatever they choose. Medicare fees are no longer based on customary and prevailing charges. Fees are limited by legislated MAAC fee limits not related to

URC. They are set yearly by the Health Care Financing Administration and implemented by Pennsylvania Blue Shield, which administers Medicare in New Jersey.

MAAC limits are very strictly enforced. Deliberate and repeat charges over the MAAC limit is punishable by a $2000 fine for each offense. There are strict national controls on what all doctors can charge. Your report stating the average senior is forced to pay up to 60% of the doctor's charges is grossly in error.

Mandatory Medicare assignment, as proposed in the Commission's Report, should be reconsidered in view of the Massachusetts experience, which led to doctors leaving the state, retiring, or excluding Medicare patients. A national representative of senior citizens said, "Given the potential access problem, the AARP cannot support mandatory assignment."

Being a Medicare beneficiary does not automatically imply financial need. Elderly Americans as a group, have the lowest poverty rate of any other age group in the nation. Certain citizens who wish medical services not permitted by Medicare, would not be allowed to contract for them.

Please be assured that medical care at a reasonable cost will be available to all senior citizens without a State law on mandatory assignment. The doctors in New Jersey have responded to the challenge of caring for the elderly at a reasonable cost.

On the subject of physician referral under Medicare, State law on physician referral is currently more restricted than national Medicare law. On February 6 of last year, SCS-734/2091 was signed into law requiring physicians to disclose to patients any referral which has a significant beneficial interest. A written copy of such disclosure must be posted in a conspicuous place in the practitioner's office.

Physician Assistant: We oppose legalizing physician assistants because this would add to health care costs, provide

no solution to the problem of accessibility of care, detract from the quality of care, and money would be better spent educating more family physicians and nurses.

Since there are almost 200 identified existing health occupations, we fail to see how adding another category could possibly decrease or contain health care costs. If physician assistants are permitted to order care, referrals, tests, and prosthetic and other devices, more health professionals with the capacity to order such things will reflect immediate cost increases. Government studies indicate utilization, not fees or salaries, is the costly factor in health care. It will cost over $50,000 to educate one physician assistant, and this will be an added burden to the taxpayers.

Their duties overlap those of other health professionals such as physicians and R.N.'s. It is never a cost saving to train professionals to duplicate services which may be performed by many other licensed professional groups.

We agree with the Report, on the living will legislation, and wish it to be enacted to enable the many seniors who desire to give Advance Directives, the legal right to do so.

Generic drugs is a very important subject. Our physician members have been aware for many years of equivalency variations with some generic drugs. Equivalency is of particular concern to patients where therapeutic effectiveness and response depends on exact dosage effectively delivered without variation. This is dependent on a pharmaceutical firm's honesty and commitment to quality control.

A generic firm recently provided phony test results to get FDA approval. Some generic firms are now being investigated by the FDA for fraud, corruption, and a range of unsafe practices. An executive of one firm admitted that capsules submitted for FDA approval were already approved "brand name" products of another company. Our physicians

desire to have a choice, as they do now, of checking off "substitution permissible" or "do not substitute," without further attesting over their signature that a brand is medically necessary. The revelations of the last 18 months have demonstrated the FDA's inability to insure the potency of generic drugs and thereby protect the consumer.

The Medical Society of New Jersey, in conclusion, studied the health problems in the State and, through extensive committee work, developed a detailed plan to expand access to care for those persons who have no insurance or who lack adequate health insurance coverage, while seeking ways to reduce the spiraling cost of health care. We support this plan. Dr. Costabile provided you with a copy.

We recognize the need for continued dialogue between the State and private disciplines to assist those in financial need with their medical care. This is a good start. Please do not eliminate your Medical Society from these dialogues.

Thank you.

SENATOR CODEY: Doctor, you came out against physician assistants but you know that they are educated at Rutgers, right?

DR. OLESNICKY: At the UMDNJ, yes.

SENATOR CODEY: Right, I'm sorry. But, once they leave there they can practice in every state in this country except the State in which they have been educated.

DR. OLESNICKY: I know that. I know that fact, but that particular fact does not make this position wrong. I really think that the impact of physician assistants would be to add to the costs of medical care, may cause detrimental care to be offered, and certainly would duplicate services that are already available.

I think mainly one group of people, especially our registered nurses, would be able to provide much of what physician assistants can do, and you would not have to

duplicate these services. You would not have to train costly new individuals. And I think it would be an immense boost to the nursing profession, which is now at such a dearth of members. We have a tremendous nursing crisis in this State.

SENATOR CODEY: Doctor, you mentioned about generic drugs, and you mentioned about phony test results.

DR. OLESNICKY: Yes, sir.

SENATOR CODEY: That's an issue of corruption.

DR. OLESNICKY: Absolutely. Absolutely.

SENATOR CODEY: Well, its got nothing to do with the quality of the drug. It's an issue for set up corruption--

DR. OLESNICKY: Absolutely. But you see--

SENATOR CODEY: --which could happen with a brand name or a generic.

DR. OLESNICKY: Senator, take for instance myself in the office writing a patient a prescription. Is the fact that my suspicion of a drug being not equivalent--

SENATOR CODEY: You can have that suspicion with a brand or a generic.

DR. OLESNICKY: It has not been brought to my attention--

SENATOR CODEY: Green doesn't know the difference between generic and brand.

DR. OLESNICKY: I think that asking the physician to write "brand medically necessary" implies that there is a specific medical necessity.

SENATOR CODEY: It would be no different than if you checked it off. The difference is the checkoff, as opposed to writing it. It takes a little more time.

DR. OLESNICKY: That, to me, is not a problem, Senator Codey. The problem, to me, is: I feel very, very insecure about generic drugs.

SENATOR CODEY: Well, then, don't prescribe them.

DR. OLESNICKY: I don't, but you know--

SENATOR CODEY: And that doesn't change anything here at all, sir.

DR. OLESNICKY: At one point, about two years ago, when I felt that generic drugs were equivalent -- until I did some research and read through the literature on the problem -- I had a patient who came to my office, and I not only said, "do not substitute," I did not write, "brand medically necessary," but I put down, "substitution permissible." That patient came back to me two days later, took her records, and went to another doctor, because even the public is aware that this is a problem.

SENATOR CODEY: But this recommendation doesn't change anything. It doesn't in any way, shape, or form change your prescribing a brand over a generic or a generic over a brand. It doesn't change it one iota.

DR. OLESNICKY: It only implies that. It implies that I can, by writing "brand medically necessary--" Certainly it's an inconvenience, and I will do that. But I would like to make sure that you are aware that there are-- For instance, digitalis--

SENATOR CODEY: But you're talking about an inconvenience of about four seconds.

DR. OLESNICKY: Fine, 20 times a day, 30 times a day. Take for instance-- There are some interesting factors in generic drugs. Bio-equivalency determination of generic drugs is very interesting because it depends on when the drug was brought to the market -- the original drug.

SENATOR CODEY: I understand, but again this recommendation doesn't change any of that. You're not talking to the issue. You're talking brand versus generic, which is not this recommendation.

DR. OLESNICKY: Okay.

SENATOR CODEY: Okay. Thank you very much, Doctor.

DR. OLESNICKY: Thank you.

SENATOR CODEY: Our next witness will be Mr. Samuel Fortunato, Commissioner of Insurance for the State of New Jersey. Good afternoon, Commissioner.

COMMISSIONER SAMUEL F. FORTUNATO: Good afternoon, Senator. I'd like to introduce Mr. Leon Moskowitz, who is a Special Deputy Commissioner of Insurance, who will be here with me today, who has done -- as you know -- a lot of work with regard to the Health Care Commission.

Let me start by saying that I commend your Committee for continuing the work which the Commission began on the problem we have of escalating health care costs in the State of New Jersey. I feel, as a Commission member, that the Commission Report represents an excellent starting point for legislative consideration.

I would also say that I think we are very fortunate that Senator Codey -- who served with distinction as a member of the Commission -- as well as Assemblyman McGreevey, are able to bridge the gaps, so to speak, between the Commission's deliberations and the deliberations and the issues which you and the Legislature will wrestle with in the months to come. I think it is very fortunate that we had the Senator and the Assemblyman having participated in the Commission's deliberations.

I think we have a three-part problem in front of us. First, the existing system has to be kept functioning. I don't think any of us want the hospitals to close down at the stroke of midnight on New Year's Eve. So I think that somehow the system has to keep functioning, which leads me to the conclusion that an extension -- a reasonable extension -- of the Uncompensated Care Trust Fund would seem to be in order, simply due to time constraints.

The second part of the problem, and the major part is, how do we control the escalating cost of medical goods and services in the State?

The last part of the problem is, how do we provide for the funding to allow those people who cannot afford medical goods and services in the State to obtain those services, and those goods? I would suggest to you that, while the funding aspect is certainly of utmost importance, you should not lose sight in your deliberations of the cost containment measures which the Commission labored long and hard to put together.

The Commission made 92 recommendations: six of them dealt with funding; 73 of them addressed specific areas of cost containment. I would suggest that it makes sense to reduce the amount that we are going to spend in health care. And if we do that, we will reduce the amount of the shortfall, which will be subject to the funding mechanism.

In regard to cost containment, we have to develop -- and I'm sure you will in your deliberations -- as broad a consensus as possible. This is a very difficult issue which you are addressing. You have to approach it from a variety of attack points. I think that you have to bring into the loop all of the providers: the hospitals, the doctors, the nurses, the pharmaceutical companies, the podiatrists, etc. We're talking here about a health care industry which in this State is estimated to cost our citizens anywhere from $12 billion to $20 billion a year, which is a substantial amount of money.

We have to bring into the consensus the insurers, and we cannot view the insurance industry simply as a pass-through mechanism. We have to have restraints on insurers, so that they adequately police their coverages and make sure that the services rendered are necessary, reasonable, and so forth. We also have to get into the consensus, those of us who pay the bills, whether we be private individuals, insurance carriers, the State government, or the Federal government.

And lastly, I would submit that the legislators and the regulators who have the responsibility to administer the program -- as it will develop -- must be brought, obviously,

into the consensus. What we have here when we look at cost containment is something which is not a silver bullet; it's not going to have an immediate payoff. It's something which is going to payoff well down the line. But I think that it has to be addressed, and I think the 72 recommendations are really gold mines if they can be looked at objectively and implemented.

Turning to the insurance area, we have to make sure in the Insurance Department that the insurance mechanism does not create a drain or a break on the problem, or exacerbate, but that the insurance mechanism helps solve the problem. And we have some specific issues I'd like to address today:

First of all, we espouse and we believe in the Commission's recommendation highlighting managed care, especially the point of service plans. We feel that point of service plans are a logical intermediate step between an indemnity type of plan and a health maintenance organization type of plan. There are bills which have already been introduced in the Legislature which would give the Department of Insurance additional powers, which we believe we need, in regulating HMOs and PPOs.

With regard to Blue Cross/Blue Shield, the Commission recommended a bifurcation of that organization. We support that for three reasons; especially, among others: First of all, Blue Cross/Blue Shield as it's currently constituted, as a large group division which handles large group cases over 50 lives, which has the small group and individual unit, which is essentially a public policy company, which is the insurer of last resort, so to speak-- We feel that in order to properly focus on the public policy aspect, that Blue Cross/Blue Shield is appropriate to bifurcate that organization so that we put a particular individual spotlight on the public policy aspect of the company.

Secondly, if after your deliberations a subsidy type of program emerges -- a subsidy for those people who cannot

afford insurance coverage -- then it would be, we believe, a cleaner and a more efficient operation to deal with a subsidy and isolated company, which would be the public policy company, as opposed to a division of a larger company, which includes a profit making arm.

Lastly, if the public policy company is to be the insurer of last resort, it should be isolated for regulatory and legislative oversight. We think that that recommendation is valid.

With regard to expansion of insurance products, we believe that we have to have more affordable products available in a marketplace, both traditional indemnity products as well as HMO and PPO products.

In regards to solvency, we feel that it is important -- obviously, since insurance is a long-term contract -- that the company has to be around at the time when the bill is presented for payment. We think that there are a couple of areas which you could consider -- which the Commission considered: one, is that, New Jersey is one of the six states in the Union -- soon to be five, after January 1 when California's law goes into effect-- We're one of six states which does not have a life and accident health guarantee fund. We believe this should be considered.

We also feel that the Department should have legislative power with regard to regulating junk bond investments of both life and P&L carriers.

Preexisting disease: In the public hearings of the Commission, I was personally very impressed by the difficulties some of the people who testified had with regard to actually being driven into poverty when they changed jobs, because their new carrier, via their place of employment, did not pick up a preexisting disease, the payment on which had been terminated by their old carrier. I feel that this is a area which must be addressed legislatively. When a person changes jobs, whether

by layoff, choice, or otherwise, the new employer's carrier should pick up, and not be able to rider out a treatment for a disease which was incurred during a prior employment.

With regard to initial coverage, there should be a reasonable period for carriers to deny claims based on preexisting illness or disease, and that should be no more than 12 months.

Lastly -- and these are only the highlights of what we see as the Commission's recommendations -- there is a need to study in-depth the medical malpractice situation in the State. I think it was apparent from the Commission's deliberations that medical malpractice goes far beyond the ken of the premiums that various medical practitioners pay for that coverage. They maintain -- and I believe it is probably accurate to a great degree -- that they must practice defensive medicine in order to insulate themselves against potential malpractice suits. This results in overutilization of expensive diagnostic equipment and medications, and drives up the costs of health care.

The Commission recommended the establishment of diagnostic protocols based on symptomatology, and if the physician follows that protocol and can so prove in a later lawsuit, there would be a rebuttable presumption in that physician's favor that he or she acted with due care. This is not a new concept. It has been introduced-- It has been in the law in the State of Maine, and we feel that that should be considered very closely because the control of excessive diagnostic equipment -- these magnetic resonance imagers and things of that type, obviously, are very expensive. To the extent that we can reduce defensive medicine, I think we all benefit.

Those are essentially the highlights of what we see as the preeminent insurance issues. Mr. Moskowitz and I would be more than happy to try to answer any questions that you have.

SENATOR CODEY: Commissioner, some of the recommendations in insurance don't need legislative action, but can be done by you. Have you started to implement any of those?

COMMISSIONER FORTUNATO: We have started on a number of these things, Senator. There are a number of areas, however, where we're sort of in a penumbra. The HMOs or the PPOs is one. We have to have the Attorney General's opinion as to whether we have adequate legislative power, or adequate regulatory power. Another one is the junk bond situation.

I would prefer that in an area where we are not certain as to whether we have the regulatory power, that we introduce, or we attack it by legislation.

With regard to those areas where we can regulate, yes, we have. We're encouraging the use of HMOs. We would like some clarifying legislation with regard to PPOs. It's not clear what our regulatory power is with regard to point of service organizations.

SENATOR CODEY: Okay. Thank you very much, Commissioner.

COMMISSIONER FORTUNATO: Thank you.

SENATOR CODEY: Our next witness is Dr. Russo, of the Northern New Jersey Chiropractic Society. Dr. Russo?

M A R K V. R U S S O, D.C.: Chairman Codey and members of the Committee, as a Board member for the New Jersey Chiropractic Society, and President of the Northern New Jersey Chiropractic Society, I'd like to introduce Dr. Arnold Cianciulli, who will address the Committee on the concerns of the chiropractic profession in regards to the Governor's Commission on Health Care Report. Dr. Cianciulli?

A R N O L D E. C I A N C I U L L I, D.C.: Good afternoon. The chiropractic profession is equally concerned with health care costs, as everyone else is. And we recognize from experience that the health care costs are driven by high tech procedures, and obviously hospital-related services.

Since 1922, when chiropractic was first licensed in this State, we have offered an alternative to various drug and surgical procedures. We have left with your Committee -- through your Chairperson, Ms. Bacon -- clinical studies which show throughout the United States, not only the clinical effectiveness of chiropractic in certain related areas such as back and neuromuscular skeletal areas, but also the cost-effectiveness.

We'd appreciate-- The concern that we have, as you do, as costs spiral, is you need innovative, thoughtful ideas, to perhaps include chiropractic. The reason for it being, that, first and foremost, patients should have a right to choose their own health care provider. Prior to 1975, they had to pay out-of-pocket, and it was the wisdom of the Legislature in 1975, to change the law to include people having the right to get reimbursement for their back conditions, for example, when they went to a chiropractic physician.

So the purpose of the legislation was not mandatory; it was an amendment to preexisting legislation, so that fairness to the patient would be first and foremost.

SENATOR CODEY: Can you just stick to the--

DR. CIANCIULLI: We're suggesting--

SENATOR CODEY: Can you just stick to the Report though?

DR. CIANCIULLI: We're suggesting, first and foremost, that your Commission take into consideration patients' civil rights, and guarantee them the right to choose whatever licensed health care provider that they have available, and that the public policy of the State of New Jersey is guaranteed by legislation.

Secondly, the chiropractic office -- what we consider non-duplication of service-- We are not doing drugs. We are not doing surgery. We have alternatives to some of these conditions, and we're prepared to defend that, and prepared to offer that.

Likewise, we feel that the encouragement of chiropractic should be part of your ambulatory care package. Rather than including an emphasis on hospitalization, we should have an emphasis on nonhospital services.

In most cases we feel that if there is going to be a managed health care package, the patient's right and the various practitioners who are licensed to serve, should be included in your managed health care package, including if your services are going to be confined to hospitals, so that we can at least offer an innovative alternative to what you have presented thus far.

That's all we have to say. Thank you.

SENATOR CODEY: Okay, but you know the Report never touched on chiropractic in any way, shape, or form?

DR. CIANCIULLI: Yes, sir. Our concern is that there has been an euphemism of mandated services, and somewhere along the line the public and press have carried mandated, i.e., alcoholism, chiropractic, AIDS-- We are sort of insulted by that kind of thing, not because of these conditions, because these are certainly conditions that have to be addressed, but we are a health service, not a disease. We're not a mandatory service; we are an amendatory service, and we'd like this Committee to be cognizant of that.

SENATOR CODEY: But the Report only suggested that the whole thing of mandates be examined -- and that's it.

DR. CIANCIULLI: Yes, we--

SENATOR CODEY: Nothing more, nothing less.

DR. CIANCIULLI: And that is what we are looking for. We bring this to your attention because we don't want to be sort of on the sidelines, and then have it pass us by -- the opportunity to discuss this with your Committee.

SENATOR CODEY: Okay.

DR. CIANCIULLI: We appreciate your efforts. Thank you.

SENATOR CODEY: Thank you. Mr. Richard Dupree, Commerce and Industry Association? (no response) Mary Adams and Jeff Beck, from U.S. Healthcare. I know you've got a briefer report somewhere?

M A R Y L O N E R G A N A D A M S, ESQ.: Pardon?

SENATOR CODEY: I know you have a briefer statement, somewhere! (laughter)

MS. ADAMS: Mr. Chairman and members of the Committee, I am Mary Lonergan Adams, Assistant Vice President of U.S. Heathcare. Thank you for allowing us to testify today. The issues of access to quality, cost-effective health care for New Jersey residents is a critical one, and we are pleased to have the opportunity to present our views.

U.S. Healthcare/HMO New Jersey, is the largest HMO in the State, with more than 388,000 members. Our total membership in our six-state service area exceeds one million persons. The U.S. Healthcare program provides access to comprehensive health care and is based on cost containment, quality, and the philosophy of preventive health maintenance.

U.S. Healthcare members also have access to a wide array of wellness programs to foster healthy living. These include healthy eating programs for weight loss and nutritional well-being, healthy breathing programs for smoking cessation, and a pioneering high risk maternity care program to help mothers-to-be deliver healthy babies.

U.S. Healthcare's commitment to preventive health care is evidenced in our breast and colon/rectal cancer screening programs. Our members lead busy lives, and many do not have the time to consider these preventive health measures, or they may not be aware of their necessity. We demonstrate our commitment to the members by notifying them at the proper time, and educating them to these risks and the value of preventive care.

As the largest HMO in New Jersey, U.S. Healthcare is deeply concerned about New Jersey health care issues. Because of that, we have been actively participating in regulatory and legislative discussions about reform. Earlier this year, we testified before the Governor's Commission on Health Care Costs and expressed our concerns. To follow up on that testimony, U.S. Healthcare developed a comprehensive proposal for recommendations for reform. We would like to present that proposal to the Committee members today, and have attached it to our testimony.

We applaud the efforts of the Commission in its difficult task, and find in the Commission's Report many excellent recommendations. Some of our recommendations appear in the Commission's final Report. However, there are many others that have not been adopted, but if enacted would contribute to a significant reduction in health care costs.

Three of the specific recommendations in the report that we believe are of merit are as follows:

1) Enact a revised HMO law to meet the modern needs of consumers and employers, and create incentives for the use of this form of managed care.

2) Enact a law that would protect all consumers -- both Medicare and non-Medicare -- from the practice of balanced billing by providers.

3) Review all mandated benefits now imposed by law to determine their cost impact, and permit health insurers to offer a minimum benefit package that would exclude those that are the least cost-effective. However, allow insurers to offer expanded coverage for competitive reasons to meet the special needs of employers and consumers.

Finally, I would like to briefly discuss several additional recommendations which we believe would assist you as you seek overall solutions:

First, we strongly urge that health care system reform must be based on quality. The incorporation of quantifiable measurements of quality into the system will reduce costs. For example, the amount of health care dollars spent annually on unnecessary and inappropriate procedures is staggering. Instituting a system that will prevent such expenditures is essential to freeing those dollars for use elsewhere.

Second, a successful health care system must contain six key components. These are:

1) economic incentives in a competitive atmosphere;

2) careful selection and recertification of providers;

3) the assessment of clinical capabilities of providers;

4) stringent monitoring of an individual's care at all stages;

5) managed care tools and techniques that payers need to keep costs lower; and

6) education of the consumer and employer.

Third, the health care delivery system that can best incorporate quality and has these six elements, is the health maintenance organization.

In closing, we again would like to thank you for allowing us to present some of our views. Our main commitment is to the consumer, and we will be pleased to work with you to ensure access to quality health care for all New Jersey residents.

I will be happy to answer any questions you may have.

SENATOR CODEY: What are your thoughts on the managed care for Medicaid patients, the plan to bring them into HMO?

MS. ADAMS: We are in agreement that the Medicaid system needs elements of managed care plans in it. At the present time, the company is working with members of the executive branch on developing possible plans. I don't know whether you are aware, but we have started a Medicaid program

in New York, and we are enrolling the initial members in that plan. So we do have a little bit of experience in the area, and we're going to review our experience there and work with the executive branch.

SENATOR CODEY: Okay. Thank you very much.

MS. ADAMS: Thank you.

SENATOR CODEY: Our next witness is Dr. Cassir.

J O R G E F. C A S S I R, M.D.: Thank you, Senator Codey and members of the Committee. As a medical practitioner in the State of New Jersey, I support some of the recommendations made in the Governor's Commission Report. At the same time, there are others which I oppose.

The call for the adoption within the next year of a universal health care system in the United States, or in the State of New Jersey, is an unrealistic time framework in which to address all the complex issues, and to engage the various participants in the process. Change must occur in a meticulous way to avoid major mistakes.

The call for the creation of a new State Health Planning Board which seems to exclude providers of health care services -- doctors and hospitals-- The development of a State Health Plan -- which should have the force and effect of State law -- and the call for a single payer system, are aimed at the creation of a powerful bureaucracy which will dictate and regulate, rather than negotiate a consensus with all the health care parties.

To mandate Medicare assignment and to rebundle reimbursement for hospital-based physicians into hospital rates, is an invasion of the right of physicians to private practice and to reasonable reimbursement for services. The rebundling concept will eventually be extended to all other physicians as the government realizes that the initial cuts taken from physicians are insufficient to pay for the expanded bureaucracy. This will, in essence, bring about the socialization of medicine; an unacceptable option.

The United States already has a good example of a low-cost universal health care system -- the VA hospital system. This is precisely the kind of a system that our State will wind up with if it rushes to implement the current recommendations of the Commission without careful consideration of the views of all participants in health care.

To plan major changes in the system, without the full participation of physicians and hospitals, will be a major strategic blunder. Patients are taken care of by doctors in their offices and hospitals, and not in the State Department of Health in Trenton. Change, no matter how well-intentioned, will not succeed without our participation, because we are the heart of the system. We are not the problem; we are part of the solution.

We physicians are a concerned group, and many of us extend free care to the indigent and accept Medicare assignment when requested. Most of us also recognize that changes are necessary in our medical delivery system and are willing to participate.

American medicine, for all its publicized shortcomings, is the best in the world because it is based on incentives and a desire to excel. Quality medicine is provided by motivated physicians and cannot be legislated. To think otherwise is naive and dishonest.

The current Commission Report and its perceived potential threats, along with the recent increase in the State income tax, are causing many of us to wonder whether we are any longer welcome in this State; and some of us may seriously consider leaving if the Report is implemented as presented. For the same reasons, it will be very difficult to attract new well-trained physicians into our State. A few years ago the State of Massachusetts experienced a significant exodus of physicians as a result of intolerable state regulations.

Let us learn from the recent historical events that tore down the Iron Curtain: Where there is no incentive, there is no future. Would you want to be a patient in a hospital in the Soviet Union? Or in a VA Hospital, for that matter?

We import electronic products from Japan and automobiles from Europe. Are we now ready to import a medical system from Canada or Great Britain? I think not, because there are enough socially responsible and intelligent individuals in our State -- physicians included -- who will work together to bring about changes needed to improve our system.

Thank you.

SENATOR CODEY: Thank you very much, Doctor. Our next witness is Mr. Robert Troast, Chairman, State Board of Ophthalmic Dispensers and Technicians.

R U S S E L L F. B E N T: Mr. Chairman, my name is Russ Bent. I've been asked by Mr. Troast--

SENATOR CODEY: There are no substitutions.

MR. BENT: No, I'm not going to substitute. I just want to tell you that he had to leave, along with your next two speakers: Mr. Kubick, and Mr. Mahire. I represent both of those groups, and they have provided written testimony to the Committee.

SENATOR CODEY: Okay. We only have the one here.

MR. BENT: You should have Troast, Kubick, and Mahire.

SENATOR CODEY: Okay. Thank you, Russ. Our next witness is Mr. John Forsman, President of the Health Care Financial Management Association. No? Myrna Hildebrant?

M Y R N A H I L D E B R A N T: Yes.

SENATOR CODEY: President of Home Health Services and Staffing Association?

J O H N A. F O R S M A N, JR.: Mr. Forsman.

SENATOR CODEY: Oh, I'm sorry

MS. HILDEBRANT: Oh, okay.

MR. FORSMAN: Good afternoon, Mr. Chairman and members of the Committee. Thank you for the opportunity to speak today. I am John A. Forsman, the President of the Health Care Financial Management Association of New Jersey. We represent 850 members in the State of New Jersey, all of the acute care hospitals, as well as many rehab and skilled nursing facilities.

We have carefully reviewed the Commission's Report. We just have a few comments that we'd like to bring forth. It appears to us that the Commission, in their recommendation, wishes to simplify the current reimbursement system. Based upon our review, we believe that many of the recommendations will, unfortunately, make the system even more complex.

Many of the recommendations, although well-meaning, will be next to impossible to implement. The goals outlined by the Commission are on a macro level. In order to be effective, we believe they must be studied on a micro level. Many of the changes, if implemented, will adversely affect hospitals. We do not feel comfortable with many of the changes, and strongly suggest there be a careful review and a phase-in policy, so as not to unfairly place hospitals at serious financial risk.

We're also concerned about the timing of, and process by which these changes will be made. The following represents the ideas and concerns of the Health Care Financial Management Association in regard to several of the proposals:

First of all, in regard to Medicaid reform, we support the expansion of the Medicaid program. With respect to the expansion into managed care, we recommend that mandatory elimination of discounts be made. In a controlled environment, encouragement of managed care cannot succeed unless a discount policy is eliminated.

Maryland has implemented this kind of restriction, and we suggest that New Jersey do the same. We support the recommendation for immediate on-site eligibility determination. This would eliminate many operational and

financial burdens incurred by hospitals, especially those with significant volumes of patients eligible for Medicaid or charity care.

With regard to hospital rate-setting reform, we recommend utilizing financial and operational performance benchmarks similar to those incorporated in Maryland. The benchmarks should be New Jersey sensitive however, and adjusted for intensity. The benchmark should also include a target measure for a reasonable operating margin, which incorporates a statewide provision for such operating margins.

We agree that there certainly is a great deal of uncertainty in hospital rates. We have experienced extreme fluctuations in their markup factors and overall rates. We would like to be able to react with issues in a fast manner, but unfortunately, the Department of Health -- the individuals that set these rates -- have been unable in the last several years to react directly to issues, which has caused a severe fluctuation of rates.

The industry, as a whole, would like these rates adjusted as infrequently as possible. Before we can get to that point, we have to go back and settle many issues that affect prior years. This will have a large impact on cash flow to the hospitals. After prior year issues have been resolved, the recommendation to set hospital rates once a year could be successful.

Historically, such issues as the Medicare shortfall and appeal items have caused the rates to fluctuate widely. If we get a better handle on these numbers with input from the industry, we think we can get the rates to be truly more perspective with a onetime adjustment early in the year.

Also, an all inclusive payment rate has been recommended. We caution the Commission as to the complexity of this issue. If any change to indirect cost is warranted, it must be done carefully, and with industry and payer input. It

also should be understood that the development of an all inclusive rate will in no way make the system any less complex. It should also be noted that Medicare has tried many times to develop an all-inclusive rate, which to date has been unsuccessful. It's imperative that guarantees be kept in the system for existing capital debt.

We also solely recommend the continuance of the current pass-through items, such as collection agency fees and malpractice insurance. These are items that are out of the control of the industry. We are not the ones that set these rates. We are the purchasers of these services.

Also, an adequate adjustment to the rate should be made each year, in order to be able to allow it to be prospective. We estimated that a prospective adjustment in the range of about 3% would make it eligible for much more prospectivity. We support the movement towards the inclusion of more standard costs in their rates. However, the coefficient variation and standard table that are in the Commission Report, coupled with combining the indirect and direct costs into one rate, may actually yield less of a standard rate. Again, this is a very complex issue that must be studied very carefully in order to make sure that the rates are adequate, as well as being accurate.

The recommendation for the Hospital Rate Setting Commission to work with the high cost of potentially insolvent hospitals should also apply to low-cost hospitals. Hospitals operating at a low cost, which could not maintain that low-cost level should be allowed to work with the Rate Setting Commission to receive additional, reasonable levels of reimbursement. We're concerned with the time that would be involved in this process. It's crucial that any review undertaken be completed, we would say, in no more than 150 days. Right now, these kinds of reviews can go on for several years at a time. That cannot go on if we expect to have a perspective system.

On the issue of collection of Medicare dollars and maximizing Medicare revenues, the hospital industry contends that they strive to collect appropriate Medicare dollars. We disagree with the position that we do not maximize the collection of Medicare revenues. We would like to see some evidence that points to the fact that we are not doing that.

I know, myself, as the President of this organization, that I have contacted the Rate Setting Commission, the Department of Health, as well as Blue Cross numerous times, and have asked them to support me in my efforts down in Washington. I've appeared before Senators and Congressmen, trying to get more Medicare dollars. To date, I have received no support whatsoever, from anyone, in that regard.

With respect to reorganizing the Rate Setting Commission, we agree that the complement of the Rate Setting Commission needs to be changed. In light of the complexities of the hospital industry, perhaps we should just get full-time salaried individuals to take these positions. This could help relieve much of the backlog and keep the current process on track, again, towards the goal of perspectivety.

We recommend that a hospital industry representative always be present on the Rate Setting Commission, especially if a voting seat is given to a payer representative. This would help to keep a fair balance on the Commission.

The recommendation to rebundle hospital-based physicians into the rates appears to have been made in an attempt to regulate physician fees. We oppose this unequivocally. It is unworkable, unreasonable, and will only impair the relationship between the hospital and its physicians. The burden to control physicians' costs cannot be placed upon the hospital. We agree that the patient's bill must be made more understandable. In order to do this, we would support the billing of charges, eliminating DRG rates and payer factors from the bill. We will also continue to support

a final reconciliation at the end of the year to make sure that hospitals have collected the appropriate amount of revenue, and have not over collected.

As far as hospital rate appeal reform, we agree with setting a fixed dollar threshold for hospital appeal. However, the proposed threshold, which is based on some dollar amount that must not exceed the total annual operating margin, we feel, is much too high. We do not believe the threshold should be tied to a hospital's operating margin.

We oppose the proposal to hold any hospital's rate adjustments until that hospital has had its appeal adjudicated. This proposal is punitive and unreasonable, because the hospitals are not at fault for the current backlog system. We have had our appeals in throughout the many years at the date they were required. It's the other side. The Department has not met its deadlines.

In regard to uncompensated care, we support the recommendation that funding for uncompensated care be done on a more broad-based basis. We would support the payer tax right now -- the employer payer tax. We oppose a fully perspective method of paying for uncompensated care. As a matter of State policy, New Jersey has always provided unlimited access to health care. If hospitals are not allowed to turn patients away, we cannot be expected to be at risk for the cost of uncompensated care. We do believe in keeping a close eye on it, making sure there are no abuses in that regard, but we do not feel that a perspective adjustment is applicable for that item. Any methodology that is used for uncompensated care must not put the hospitals at risk in an all payer system.

If there are any questions, I'd be happy to answer them at this time.

SENATOR McMANIMON: I would appreciate a copy of that, if you can make a copy for us?

MR. FORSMAN: Certainly.

SENATOR McMANIMON: I'd appreciate it very much. Thank you very much.

MR. FORSMAN: Thank you.

SENATOR McMANIMON: Our next witness will be Myrna Hildebrant, President, Home Health Services and Staffing Association.

MS. HILDEBRANT: Good afternoon, members of this austere Committee. I'd also like to say hello to Senator Codey, but he has stepped out for a minute.

My name is Myrna Hildebrant. I am President of the Home Health Services and Staffing Association of New Jersey. This is an industry association representing more than 350 providers of home health care. We provide nursing, home health aide, homemaker, and respite care services to all age groups in New Jersey. All of our member organizations are registered with the Bureau of Employment and Personnel Services of the Division of Consumer Affairs, many in the Temporary Help Service Section.

HHSSA believes that in a weakening economy, recommendations for a broad-based employer tax of each employee's wages -- which was recommendation CR-88 -- and penalties on employers who do not provide health insurance coverage for their employees -- CR-90 -- will burden employers and employees already experiencing financial problems. Mandatory insurance offers a quick-fix solution and does not address the issue of why many businesses cannot afford to offer insurance coverage. Because of the uniqueness of temporary help -- these are employees who work irregularly and are often transitory -- mandatory insurance coverage is grossly unfair.

A temporary worker in the home health industry, for example, might earn as little as $100 for the year -- not uncommon, given the transitory nature of the industry -- and yet the employer would be penalized $750 for not providing health insurance coverage. Or a temporary worker may be

employed by more than one agency simultaneously, and full-time by none of them. It could be a weekend case with one agency, a couple of days with another. Who provides the coverage? Many employers would be penalized for the same employee. Determination, the paperwork, the book work, etc. in itself, would be costly.

Registered temporary agencies providing home health care have the added burden of offering care for the elderly, disabled, and indigent, as provided by Medicaid-funded programs at a locked-in reimbursement rate set by the Department of Human Services. Our home health aides earn an average hourly base rate of $7.75 per hour, and with the addition of benefits given to them such as Social Security, State Unemployment/Disability, Workers' Compensation, liability insurance, transportation, nursing supervision, and quality assurance, costs run to approximately $14 per hour -- a far cry below the present reimbursement rate of $11 per hour.

This would create an added hourly cost increase of between $1.25 and $1.50. Procurement of increases presently has been herculean, and this would only add to the strain. Our reimbursement rates for these programs are derived from the Casino Revenue Fund, representing a small piece of the pie and overshadowed by the formidable and insatiable PAAD.

Who will suffer? The people needing health care services at home. Agencies will not be able to afford caring for these people and will discontinue participation, opting for private cases. Hence, many will suffer needlessly; many will be institutionalized. Besides the emotional tragedy of such a scenario, health care services provided at home, cost one-third less than institutional care. Certainly, it is more cost-effective for the State's budget.

Another realization regarding these two recommendations -- CR-88 and CR-90 -- is that insurance penalties for businesses would be an inducement to initiate a

reduction in part-time workers in efforts to avoid costs generated by mandatory health insurance coverage.

HHSSA agrees that reform is needed. We also feel that there is a need to collect accurate data on who is being serviced by the Uncompensated Care Trust Fund. Meaningful reform cannot be enacted upon without in-depth understanding of the problem. We agree that a complete audit of this Fund is imperative. Vigorous collection of bad debts, which represent 82% of the funds, including those that refuse to pay, must be implemented.

Small businesses are the fastest growing sector with regard to employment opportunity. A broad-based employer tax on employees' wages and mandatory insurance coverage would smother the industry. Opportunities for workers, especially the young, the elderly, and the part-time worker, would be jeopardized.

Bankruptcies and other financial troubles would proliferate in a segment of the economy that is already economically vulnerable. Two-thirds of all bankruptcies are in the service and trade industries, and two-thirds are among small firms. This will directly impact on home health care services, as a large percentage of our industry is made up of small businesses.

Thank you.

SENATOR McMANIMON: Myrna, thank you very much. We are conscious of the effect that it is going to have on the small business industry in this State, and you can fully understand why this hearing is so vitally needed.

MS. HILDEBRANT: Yes.

SENATOR McMANIMON: Today we are being presented a complete cross section, and I'm sure that before any action is taken, you can rest assured that these particular issues will be well discussed.

MS. HILDEBRANT: Thank you, Senator McManimon.

SENATOR McMANIMON: Thank you very much. Our next witness is Carol Kientz, President, Home Health Assembly.

C A R O L J. K I E N T Z, R.N., M.S.: Thank you very much for the opportunity to present additional testimony this afternoon on behalf of the home care industry. I am Carol Kientz, President of the Home Health Assembly of New Jersey, an organization which represents over 100 home health agencies and providers of home care services, including the Visiting Nurses Association, hospital-based home care agencies, proprietary providers of home care services, and the like.

Some of what I am saying will be an echo of what my colleague Myrna Hildebrant presented to you. These also represent issues of concern to the Home Care Council of New Jersey.

The intent and basic conclusions of the Commission Report have to be supported by health care providers concerned about the unmet health care needs of the uninsured and inadequately insured. For years, the New Jersey home care provider community has been voicing its concern for the "no care zone" -- the elderly and disabled, as well as the acutely ill -- who cannot afford any long-term maintenance or acute care, let alone the right to choose where and how they want to receive the care.

The recognition by the Commission of the appropriateness and cost-effectiveness of home care to meet chronic long-term care needs, a variety of acute care needs, including people with AIDS, and compassionate family-oriented terminal care is, indeed, satisfying. Home care advocates are no longer prophets crying in the wilderness. The home care industry is committed to working together with the Commission and the Legislature to make home care available to every New Jersey citizen who wants and needs this economical and humane alternative.

It should be noted that the cost-effectiveness of home care is further enhanced by the fact that its roots lie in preventive health care, and its goal is always maximizing the potential of the individual and family for self-care and independence. Finally, community health nurses traditionally provide the patient not only with treatment services, but with health education and over all family health assessment and case management, as well.

Therefore, the Commission's recognition that some health care may be more appropriately and economically delivered by skilled nursing professionals is also a de facto endorsement, we feel, of the essential system of home care in this State.

That being said, it must be noted, however, that there are unique aspects of the home care industry in New Jersey which make the proposed funding methods for totally insuring our population difficult to resolve and in need of study.

One of the most significant facets of home care in the State is home health aide services, as you just previously heard. Homemaker home health aides are employees at the low rung of the pay scale -- not to belabor the fact; information you've already received -- just to summarize some of this. We are concerned about the Medicaid rate. We know and appreciate Senator McManimon's concern about this, and hope that something can be done, in terms of casino revenue surpluses, very quickly to assist -- to at least get our providers up to costs so that we won't have more and more providers saying, "No, we can't provide Medicaid services at this point, let alone more services in the future," if that should be the direction of the Commission's thrust.

The problem is further complicated, as you've heard, by our home care home health aide employees often working for a variety of employers, for a variety of schedules. They have multiple employers at the same time, and are working in very erratic patterns. This is a concern, as well, of the industry.

It may well be that opening up the State's Medicaid eligibility to low-income employees could help resolve this problem, while also having the advantage of Federal matching funds. Opening the Garden State Health Plan may be another feasible alternative, though the Plan's current pace of enrollment of Medicaid recipients calls into question when, if ever, it will be prepared to enroll a whole new level of individuals. Some type of cost-effective industry self-insurance coupled with raising Medicaid home care reimbursement rates to at least a cost level with appropriate annual adjustments, is also a concept worth investigating, and the industry is certainly willing to work on this.

Finally, while the home care provider community applauds the concept of case-managed health care, it does so with a strong caution. Case management is only as good as the individual case manager. The best constructed system falls apart when the case manager is not adequate to fill the role. Designing an individualized patient- and family-centered care plan which maximizes family talents, patient independence, and creative use of community resources, while also utilizing the most cost-effective levels and loci of care and which in addition are the most medically safe and appropriate, requires the skill of an experienced health care professional familiar with all available modes of care, resources, and patient and family assessment methods.

Cases in point exist right here in New Jersey. Medicaid waiver programs, including ACCAP and CCPED, are case managed. When those managers are experienced professionals such as community health nurses, we have seen case management which is nothing short of brilliant in terms of both safe, effective, and economical care and client satisfaction. However, in the instances in which inadequately prepared and inexperienced individuals acted as case managers, significant failures to address client needs were evident. Fortunately, these latter have been in the minority, so far.

From the standpoint of private health maintenance organization case management, there are also successes and failures -- at least in terms of meeting clients' needs. The home care industry, nationwide, has even found it necessary to sue Medicare-eligible HMOs to force their compliance with Federal regulations stipulating that they must provide the care needed by the individual. Such suits have unfortunately been needed because many HMOs believe that the most cost-effective care is little or no care.

Thus, the trend toward managed care, while very appropriate, must be combined with safeguards to protect client safety and insure the use of capable case managers.

To summarize, though there is unquestionable support for a method to adequately insure the health care needs of every New Jerseyan, while also directing health care towards a cost-effective, client preferred alternative, including home health care, there are unique concerns to the home health care industry which must be resolved if the industry is to provide the amount and quality of care potentially needed in such a health care system.

These concerns include large numbers of uninsured per diem individuals, often working for multiple employers, and inadequate State home care reimbursement rates making it impossible to provide universal employee benefits at these rates.

Additionally, there is a need to guarantee adequate safeguards for any case-managed health care system. These concerns are not insurmountable, and the time is right to resolve them and make progress toward a fair and comprehensive health care system for New Jersey.

I thank you very much.

SENATOR McMANIMON: Carol Kientz, thank you very, very much for your presentation. Our next witness will be Lois Yates, Rite Aid Corporation.

L O I S B. Y A T E S: Good afternoon. I'm Lois Yates, and I'm testifying on behalf of Rite Aid Corporation. I'm here to address the problem of out of control drug costs in the PAAD program, as well as the need to facilitate the use of generic drugs for the general public through Senator Codey's bill, S-1272, which has the "brand medically necessary" requirement when prescribing prescription drugs.

Culkin and Mendell of the New Jersey Department of Health wrote, "If prescriber disapproval of generic substitution were decreased to even 10% in New Jersey, statewide consumer savings would be increased by approximately $19 million to $29 million annually." This is if generic substitution is increased by 10%. They also cited an estimated savings of approximately $7 million by the 1985 New Jersey Medicaid program, and approximately $7 million by the 1986 New Jersey PAAD program.

If you look at the average payment per recipient for PAAD in 1986, it was $351 versus $611 in 1990. If $7 million could have been saved in 1986, think what could be saved if all the drugs that could be substituted for generic, were. I can only guess by using the 1986 figure that the 1990 savings would far exceed twice that.

Pennsylvania signed legislation similar to Senator Codey's bill two-and-a-half years ago, and they estimated they saved $30 million in their first year in their Medicaid and PACE Programs. At least 29 states have passed this legislation.

New Jersey is a large pharmaceutical manufacturing State, and you may be hearing from some pharmaceutical manufacturing companies that this legislation may cause potential health risk for New Jersey consumers. As patents on some best selling prescription drugs expire, the makers have turned on a propaganda war against their generic competitors in order to insure that you keep paying top dollar. Of all the generic drugs used in the U.S. today, at least 60% are sold by

brand name companies. In addition, generic products are subject to the same FDA standards as brand name products.

NJPIRG recently did a study on prescription drug costs and found that, on the average, brand name drugs cost 54% to 233% more than generic drugs, for the same strength and quantity of drugs surveyed. Here are two examples: Valium, one of the most widely prescribed drugs on the market, costs on average $42.47 for 100, 5mg of the name brand. If the generic brand is used, the average price is $12.74 for 100, 5mg tablets. One hundred Tylenol 3 tablets cost $23.75 versus $12.73 for the generic brand.

New Jersey currently has a statutory provision concerning generic substitution. The Drug Utilization Review Council is to determine the therapeutic equivalency of putative generic substitution for branded products. A generic substitution formulary listing acceptable generic products is to be prepared and distributed without charge to all prescribers and pharmacists. So you see, New Jersey does have oversight in this area.

In summary, this is one area where we can painlessly plug up the hole of money being wasted. I hope the Committee will consider acting immediately on mandating generic substitution in the PAAD program, as well as Senator Codey's bill, S-1272.

If we can stop the millions of dollars from being wasted, and put it into the home care provider where it belongs, even more money would be saved. By providing home care for the frail, elderly, and disabled, the State of New Jersey would not be sending them to nursing homes, which cost three times what home care cost. Also with home care, there is less hospitalization required. When the frail, elderly, and disabled require hospitalization because there's no home care provider, they cannot pay the hospital bill, and it goes to the Uncompensated Care Trust Fund for payment.

This has become a vicious circle and we can began to stop it by now.

SENATOR CODEY: Thank you. By the way, my name is spelled C-O-D-E-Y, Lois. You spelled it wrong.

MS. YATES: All right.

SENATOR CODEY: Okay. We stand adjourned. Thank you very much.

(HEARING CONCLUDED)

APPENDIX

"The world is divided into those who want to become someone and those who want to accomplish something. There is less competition in the second category."

Jean Monnett 1888-1979

Chartered September 25, 1961 

NEW JERSEY STATE AFL-CIO
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November 9, 1990

TO ALL STATE LEGISLATORS:

First, let me thank everyone of you who attended our four recent meetings around the state. We will not forget your concern. Secondly, let me apologize for this form-letter, but since our office staff has been hard hit by the flu, it is the only way we can get our message out to you immediately.

The recommendations put forth by the Governor's Commission on Health Care Costs are among the most important legislative and policy proposals of the past 25 years. If enacted, they will have an enormous and beneficial impact upon the health and welfare of our residents and the economic fabric of our state.

For six intensive months, commission members received extensive testimony from health care providers, payors, insurers, large and small business owners, consumers, senior citizen groups, health care experts, and representatives from organized labor. All parties were given a full hearing and their points of view were given due consideration.

The commission achieved a broad consensus on each of its 92 recommendations for reform and uninimity on most. It was universally accepted by witnesses and members of the commission alike that our current system of funding uncompensated care is discriminatory and inequitable and must be revised if we are to achieve true reform.

As co-chairman of the commission, I can assure you that there was no pressure or influence brought against the commission by the administration or any other group, nor was their any attempt to reach pre-conceived conclusions. All commission members were given every opportunity to express their opinions, and the recommendations were made independent of outside pressures.

Two commission recommendations in particular (#83 & #88) would eliminate the existing 19% hidden tax for uncompensated care and replace it with a more equitable, broad-based, one percent employer levy. These recommendations are absolutely critical to reform because they would eliminate what is perhaps the most onerous of all aspects of our current health care system and provide the funding for subsidies to create low-cost, managed care insurance products.

THE ELIMINATION OF THE HIDDEN TAX ON UNCOMPENSATED CARE (NOW AFFIXED TO ALL INSURANCE PREMIUMS AND HOSPITAL BILLS), AND ITS REPLACEMENT BY A ONE PERCENT EMPLOYER TAX, WILL SAVE EVERY EMPLOYER AND CONSUMER WHO NOW PURCHASES HEALTH CARE INSURANCE OR PROVIDES IT TO HIS EMPLOYEES MORE THAN 70% ON THEIR HEALTH CARE TAX IN 1991.

Here is how it will work for a small business owner with 12 employees who now spends $50,000 a year to provide health insurance. Approximately 55% of the cost of health insurance is attributable to acute care costs (that portion affected by the uncompensated care tax), or $27,500. In 1990, an average of 19% of that cost is the hidden tax for uncompensated care, or $5,525. Based on the annual rise in uncompensated care costs since 1983, it can be safely assumed that the hidden tax will total 23% in 1991, or some $6,325 on a $50,000 premium.

Therefore, if the hidden tax is eliminated, as recommended by the commission, an employer will save $6,325 on a $50,000 premium in 1991.

That same employer will be paying a new one percent assessment on each of his employees (based on $14,400 the top unemployment insurance level of deduction), or some $144 per employee per year, as will all other employers in the state whether they provide health insurance or not. For 12 workers, the $144 assessment will total $1,728. If the $1,728 in new expenditures in 1991 is subtracted from the estimated $6,325 in new savings, we see that this employer will have a net savings of $4,597 under the commission's proposal, or a savings of nearly 72% on his health care tax.

Larger employers with larger premiums will save proportionately more under the new system, but every employer who now provides coverage will save an average 72% on the health care tax that he doesn't even know he is now paying.

If the commission's recommendations are enacted immediately, the Legislature will, in effect, be replacing an overall 12.6% tax on every insurance premium and hospital bill with a 3.6% tax in 1991. We will be slashing health care taxes by nearly 72% for every employer who provides coverage to his workers; for hundreds of thousands of individual subscribers who purchase an insurance policy; for every union health and welfare fund that provides coverage for its members, and for everyone who pays their hospital bill out of pocket.

In addition, local, county and state taxpayers will save, because their governing bodies will be able to reduce the cost of health care coverage for public employees. For instance, state government paid-out $60 million in uncompensated care costs in 1989.

Just as important, this new system will finally place controls on uncompensated care costs which have been escalating at the rate of 17% a year. Unless something is done immediately to stop this trend, the tax will be 27% in 1992 and an incredible 43% by 1995 with no end in sight (see attached chart). Very simply, the cost will be an economic disaster for New Jersey, driving corporations out of business, forcing union health plans into bankruptcy, and making paupers out of a whole generation of health care consumers.

As to whether the public will accept a new tax on employers to replace the

much higher "hidden" tax, it's safe to say they will jump at the idea. In fact, a recent poll conducted by the Bergen Record shows that 75% of the men and women interviewed said employers should be required to provide health insurance for everyone that works, and 60% of the respondents support broad-based health coverage, even if it means paying higher taxes.

Reform of New Jersey's uncompensated care system is not an issue that can be delayed for another year or two. It is already responsible for a loss of jobs and quality health care coverage in New Jersey, and it will soon be responsible for the bankruptcy of numerous union health and welfare plans.

The Governors's Commission on Health Care Costs has proposed a fair and workable solution to the problem. We urge you to give it your careful consideration and enact it. The very future of our state depends upon it.

Sincerely,

Charlie Mamaux

CHM:mr
opeiu-20
afl-cio

Enc.

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GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

*Projected benefits/savings of replacing 19% hidden tax on uncompensated care with 1% employer tax per employee

(Recommendations 83 & 88)

	Premium	**Hidden Tax		***Employers Tax		Net Savings
1990	$ 25,000	2,612.50	(19%)	864		1,748.50
1991	25,000	3,162.50	(23%)	864	(6)	2,298.50
1992	25,000	3,712.50	(27%)	864	Employees	2,848.50
1993	25,000	4,331.25	(31.5%)	864		3,467.25
1994	25,000	5,087.50	(37%)	864		4,223.50
1995	25,000	5,912.50	(43%)	864		5,048.50
1990	50,000	5,225.00	(19%)	1,728		3,497.00
1991	**50,000**	**6,325.00**	**(23%)**	**1,728**	**(12)**	**4,597.00**
1992	50,000	7,425.00	(27%)	1,728	Employees	5,697.00
1993	50,000	8,662.50	(31.5%)	1,728		6,934.50
1994	50,000	10,175.00	(37%)	1,728		8,447.00
1995	50,000	11,825.00	(43%)	1,728		10,097.00
1990	100,000	10,450.00	(19%)	3,600		6,850.00
1991	100,000	12,650.00	(23%)	3,600	(25)	9,050.00
1992	100,000	14,850.00	(27%)	3,600	Employees	11,250.00
1993	100,000	17,325.00	(31.5%)	3,600		13,725.00
1994	100,000	20,350.00	(37%)	3,600		16,750.00
1995	100,000	23,650.00	(43%)	3,600		20,050.00
1990	500,000	52,250.00	(19%)	18,000		34,250.00
1991	500,000	63,250.00	(23%)	18,000	(125)	45,250.00
1992	500,000	74,250.00	(27%)	18,000	Employees	56,250.00
1993	500,000	86,625.00	(31.5%)	18,000		68,625.00
1994	500,000	101,750.00	(37%)	18,000		83,750.00
1995	500,000	118,250.00	(43%)	18,000		100,250.00
1990	1,000,000	104,500.00	(19%)	36,000		68,500.00
1991	1,000,000	126,500.00	(23%)	36,000	(250)	90,500.00
1992	1,000,000	148,500.00	(27%)	36,000	Employees	112,500.00
1993	1,000,000	173,250.00	(31.5%)	36,000		137,250.00
1994	1,000,000	203,500.00	(37%)	36,000		167,500.00
1995	1,000,000	236,500.00	(43%)	36,000		200,500.00

* In effect, under the recommendations of the Governor's Commission on Health Care Costs, in 1991 a 12.6% tax on a total insurance premium or hospital bill will be replaced by a 3.6% tax, resulting in overall tax savings of nearly 73%.

** Hidden tax percentages based on annual 17% increase in uncompensated care.

*** Employer tax set at $144 per employee. This figure will increase only minimally, based on any increase in the state's average weekly wage.

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Louis P. Scibetta FACHE
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TESTIMONY OF LOUIS P. SCIBETTA,

PRESIDENT, NEW JERSEY HOSPITAL ASSOCIATION

BEFORE THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

NOVEMBER 14, 1990

5X

GOOD MORNING SENATOR CODEY AND MEMBERS OF THE COMMITTEE. THANK YOU FOR GIVING THE NEW JERSEY HOSPITAL ASSOCIATION THE OPPORTUNITY TO COMMENT ON THE RECOMMENDATIONS CONTAINED IN THE REPORT OF THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS. THE GOVERNOR'S COMMISSION SHOULD BE COMMENDED FOR UNDERTAKING THEIR SIX MONTH REVIEW OF OUR HEALTHCARE SYSTEM IN NEW JERSEY AND TACKLING SOME OF THE TOUGH ISSUES WHICH CONFRONT US ALL. AS I NOTED SOME MONTHS AGO, FOR THE FIRST TIME IN MORE THAN A DECADE, REAL OPPORTUNITY FOR CHANGE IS AT HAND FOR ALL PARTICIPANTS IN THE HOSPITAL INDUSTRY AND NEW JERSEY'S HEALTHCARE DELIVERY SYSTEM.

EVERYONE: HOSPITALS, REGULATORS, PAYORS, LABOR AND INDUSTRY, LEGISLATORS, CONSUMER GROUPS, ARE NOW BEGINNING TO STOP "BUMPING THE BLAME" FOR PROBLEMS THAT WE ALL HAD A HAND IN CREATING -- PROBLEMS WE ALL SHOULD LEND A HAND IN SOLVING.

PEOPLE ARE BEGINNING TO COME TO THE TABLE WITH IDEAS AND A NEW TOLERANCE FOR CHANGE, AND PERHAPS AN URGENCY FOR SIGNIFICANT CHANGE TO TAKE PLACE SOON. OUR CHALLENGE IS TO AGREE ON THE SOLUTIONS THAT WILL SHAPE THE NEW JERSEY HEALTHCARE SYSTEM FOR THE DECADE AHEAD.

THIS IS CLEARLY A CHALLENGE FOR GOVERNMENT AS WELL, SINCE ONLY PROVIDERS CAN DELIVER GOOD QUALITY, EFFICIENT HEALTH AND HOSPITAL SERVICES. GOVERNMENT MUST ESTABLISH THE ENVIRONMENT IN WHICH THIS OCCURS.

THE NEW JERSEY HOSPITAL ASSOCIATION IS VERY PLEASED THAT A NUMBER OF THE HOSPITAL INDUSTRY'S CONCERNS WERE ADDRESSED IN THE FINAL REPORT OF THE GOVERNOR'S COMMISSION AND I WOULD LIKE TO EXPAND UPON SOME OF THOSE RECOMMENDATIONS FOR CHANGE IN MY TESTIMONY TODAY. IN PARTICULAR, I WILL DISCUSS METHODS TO FUND UNCOMPENSATED CARE, THE NEED TO FIND NEW AND INNOVATIVE WAYS TO INSURE THE UNINSURED AND NEEDED REFORMS TO THE HOSPITAL REIMBURSEMENT SYSTEM. FINALLY, I WANT TO ADDRESS SOME MISINFORMATION ABOUT HOSPITALS' BAD DEBT COLLECTION EFFORTS AND THE MEANING OF CHARITY CARE.

WITH 92 RECOMMENDATIONS COVERING A WIDE RANGE OF ISSUES FROM "TORT REFORM" TO STUDENT LOAN FORGIVENESS FOR PHYSICIANS PRACTICING IN MEDICALLY UNDERSERVED AREAS, TIME DOES NOT PERMIT ME TO COMMENT ON EVERY ISSUE OF INTEREST TO NEW JERSEY HOSPITALS. THEREFORE, I WOULD LIKE TO CONFINE MY REMARKS TODAY TO SEVERAL MAJOR TOPICS AND ASSURE THE COMMITTEE THAT WHEN ACTUAL REGULATIONS AND DRAFT LEGISLATION ARE INTRODUCED, NJHA WILL RESPOND TO THOSE INITIATIVES.

IN JULY, THE HOSPITAL ASSOCIATION SUBMITTED A REPORT TO THE GOVERNOR'S COMMISSION ENTITLED: <u>HOSPITAL REGULATION AT THE TURNING POINT: OPPORTUNITY FOR CHANGE</u>. OUR REPORT CONTAINED 28 SUGGESTIONS FOR CHANGING OUR HEALTHCARE REGULATORY AND REIMBURSEMENT SYSTEMS. I WILL REVIEW THE KEY SUGGESTIONS FOR CHANGE AND DISCUSS HOW WE ARRIVED AT OUR RECOMMENDATIONS.

IN MARCH, NJHA ASSEMBLED A PRESIDENT'S TASK FORCE CONSISTING OF 17 HOSPITAL CHIEF EXECUTIVES AND TRUSTEES FROM THROUGHOUT THE STATE ALONG WITH OUR ASSOCIATION'S EXECUTIVE COMMITTEE. THE TASK FORCE MET FREQUENTLY OVER A FOUR MONTH PERIOD, REVIEWED MATERIAL FROM OTHER HIGHLY REGULATED STATES AND DEBATED AND DISCUSSED THE TYPE OF HOSPITAL REGULATORY SYSTEM WE WOULD LIKE TO SEE IN NEW JERSEY AS WE TURN THE CORNER INTO A NEW DECADE.

OUR TASK FORCE ALSO SOUGHT OUT THE OPINIONS OF OTHER GROUPS WHO WERE INTERESTED IN REFORMING OUR CURRENT SYSTEM OF HOSPITAL REGULATION. THE GROUPS INCLUDED: BUSINESS, LABOR, PAYORS, PROVIDERS, CONSUMER ADVOCATES, FORMER REGULATORS AND REPRESENTATIVES FROM THE HOSPITAL INDUSTRY IN OTHER STATES.

AS I STATED DURING MY TESTIMONY BEFORE THE GOVERNOR'S COMMISSION ON JUNE 12, WE CONCLUDED THAT "NEW JERSEY HOSPITALS NEED TO DO MORE THAN JUST SURVIVE. HOSPITALS MUST BE ABLE TO OPERATE WITHIN A SYSTEM THAT ENSURES ADEQUATE, EQUITABLE AND PREDICTABLE PAYMENT LEVELS, WHILE GUARANTEEING ACCESS TO CARE FOR NEW JERSEYANS REGARDLESS OF THEIR ABILITY TO PAY."

THE MOST PRESSING CONCERN OF OUR TASK FORCE AND THE ISSUE WHICH KEPT THE GOVERNOR'S COMMISSION IN LENGTHY SESSIONS WAS THE DEVELOPMENT OF A MORE EQUITABLE MECHANISM FOR PAYING FOR HOSPITAL UNCOMPENSATED CARE. THE NEW JERSEY HOSPITAL INDUSTRY SUPPORTS THE PREMISE THAT THE BROADER THE BASE OF FINANCIAL SUPPORT, THE MORE EQUITABLE THE SYSTEM WILL BE. THE COMMISSION'S CALL FOR THE ADOPTION OF AN UNCOMPENSATED CARE FUNDING MECHANISM THAT INVOLVES A PAYROLL DEDUCTION OF $144 PER EMPLOYEE TO BE PAID BY THE EMPLOYER IS ONE SUCH BROAD-BASED FINANCING MECHANISM.

HOWEVER, NJHA BELIEVES THAT THE LONG-TERM SOLUTION TO OUR STATE'S UNCOMPENSATED CARE PROBLEM LIES IN REDUCING THE NUMBER OF UNINSURED PERSONS WHO MUST RELY ON THE UNCOMPENSATED CARE TRUST FUND. WE APPLAUD THE GOVERNOR'S COMMISSION FOR RECOGNIZING THAT INSURANCE COVERAGE MUST BE EXPANDED IF WE ARE GOING TO ATTACK THE REAL CAUSE OF RISING UNCOMPENSATED CARE COSTS. THE COMMISSION'S CALL FOR AFFORDABLE, APPROPRIATE INSURANCE PRODUCTS FOR THE SMALL BUSINESS MARKET MAKES SENSE. TAX CREDITS OR INCENTIVES TO ENCOURAGE BUSINESSES TO PROVIDE INSURANCE TO THEIR EMPLOYEES SHOULD BE STUDIED IN GREATER DETAIL.

OUR TASK FORCE URGED STATE AND LOCAL AGENCIES TO PLACE WORKERS ON SITE IN NEW JERSEY HOSPITALS TO ENROLL MORE MEDICAID ELIGIBLE CLIENTS. BECAUSE OF THE FEDERAL MATCH, WE FELT THAT THIS SUGGESTION WOULD INCREASE NEW JERSEY'S MEDICAID FUNDS FROM THE FEDERAL GOVERNMENT. THE GOVERNOR'S COMMISSION REPORT ACTUALLY EXPANDED ON OUR CALL FOR ON-SITE MEDICAID ASSISTANCE WORKERS IN SUGGESTING THAT THESE WORKERS HAVE THE AUTHORITY TO MAKE ON-SITE ELIGIBILITY DETERMINATIONS AND PRESUMPTIVE ELIGIBILITY DECISIONS. WE STRONGLY AGREE AND OF COURSE, SUPPORT THIS ACTION.

A BRIGHT SPOT IN THE RECENTLY ENACTED FEDERAL BUDGET WAS THIS SAME PROPOSAL WHICH IS NOW MADE A PART OF THE FEDERAL MEDICAID LAW. THIS SHOULD SERVE TO REDUCE OUR UNCOMPENSATED CARE EXPENDITURES.

TURNING NOW TO THE STATE'S HOSPITAL REIMBURSEMENT SYSTEM, WE CONCUR WITH THE COMMISSION'S ASSESSMENT THAT NEW JERSEY NEEDS A NEW HOSPITAL PAYMENT SYSTEM WHICH IS LESS COMPLEX, MORE PROSPECTIVE, MORE PREDICTABLE, MORE TIMELY IN ITS ADMINISTRATION AND WHICH LIMITS THE NUMBER OF COSTLY APPEALS. ONE OF THE KEY

COMPONENTS OF THIS SYSTEM WOULD BE A WRITTEN POLICY THAT WOULD ESTABLISH FINANCIAL BENCHMARKS. THESE BENCHMARKS WOULD PROVIDE A UNIFORM STANDARD BY WHICH THE EFFECTIVENESS OF THE HOSPITAL REGULATORY SYSTEM AND THE FINANCIAL STABILITY OF HOSPITALS COULD BE DETERMINED.

AGAIN, WE WERE PLEASED TO NOTE THAT THE GOVERNOR'S COMMISSION CONCLUDED THAT SUCH BENCHMARKS WERE NECESSARY.

THE BACKLOG OF HOSPITAL RATE APPEAL THREATENS THE FINANCIAL VIABILITY OF MANY OF OUR HOSPITALS AND THREATENS TO STRANGLE THE HOSPITAL RATE SETTING PROCESS. THE GOVERNOR'S COMMISSION INDICATED THAT THESE "APPEALS MUST BE SETTLED QUICKLY" OR WE FACE THE CONTINUED PROBLEM OF RETROACTIVE RATE ADJUSTMENTS WHICH ARE NOT IN HOSPITALS', PAYORS' OR THE PUBLIC'S BEST INTEREST.

THE DEPARTMENT OF HEALTH HAS RECENTLY EMBARKED UPON AN AMBITIOUS PROGRAM OF SETTLEMENT OFFERS FOR A LOG-JAM OF HOSPITALS' OUTSTANDING APPEALS FROM 1985 TO THE PRESENT. IF THE DEPARTMENT OF HEALTH'S SETTLEMENT OFFERS REPRESENT A FAIR RESOLUTION OF PAST MONEY OWED TO HOSPITALS, I AM CONFIDENT THAT OUR HOSPITALS WILL ACCEPT THE OFFERS AND THE BACKLOG CAN BE CLEARED. HOWEVER, IF THE OFFERS ARE NOT FAIR, THE UNACCEPTABLE STATUS QUO WILL CONTINUE.

AS WE HIGHLIGHTED IN OUR TASK FORCE REPORT THIS SUMMER, ONE OF THE ELEMENTS OF THE CURRENT REGULATORY SYSTEM WHICH WE FIND COUNTERPRODUCTIVE IS THE EXCESSIVE CENTRAL CONTROL BY THE DEPARTMENT OF HEALTH. TOO MUCH AUTHORITY IS CONCENTRATED IN ONE JURISDICTION WHICH REDUCES LOCAL INPUT AND OFTEN NEGATES THE MORE MEANINGFUL ROLE OF HOSPITAL BOARDS AND MANAGEMENT. THIS EXCESSIVE CONTROL HAS LED TO THE TYPE OF MICRO-MANAGEMENT OF HOSPITALS WHICH IS COSTLY AND INEFFICIENT. I FEAR THAT SOME OF THE COMMISSION'S PROPOSALS IN THE HEALTHCARE PLANNING AND REGULATORY ARENA EXACERBATES THIS TREND TOWARDS MICRO-MANAGEMENT. I HOPE THAT WE CAN WORK WITH YOU AND THE DEPARTMENT OF HEALTH TO ARRIVE AT A HOSPITAL REGUALTORY SYSTEM WHICH IS BOTH EFFECTIVE AND EFFICIENT.

FINALLY, I WANT TO ADDRESS THE ISSUES OF BAD DEBT AND CHARITY CARE, THE TWO OFTEN CONFUSED COMPONENTS OF UNCOMPENSATED CARE. NEW JERSEY HOSPITALS ARE DOING A GOOD JOB OF COLLECTING BAD DEBTS FROM PATIENTS WHO WILL NOT PAY THEIR BILLS, IN PART, BECAUSE THE SAME LAW THAT ESTABLISHED THE TRUST FUND ALSO IMPOSED ON HOSPITALS THE MOST RIGOROUS CREDIT AND COLLECTIONS REGULATIONS IN THE COUNTRY. HOSPITALS IN NEW JERSEY FOLLOW A 17-STEP ADMISSIONS REGISTRATION PROCESS AND A 23-STEP COLLECTION PROCESS THAT INCLUDED COLLECTION PHONE CALLS, LETTERS, TELEGRAMS AND LEGAL ACTION TO RECOVER BAD-DEBT MONIES. ALSO, THE STATE CONTINUALLY AUDITS HOSPITALS' UNCOMPENSATED CARE CLAIMS. IF A CLAIM IS FOUND TO BE NOT VALID, THE HOSPITAL DOES NOT RECEIVE PAYMENT.

NEW JERSEY LIMITS "FREE CARE" TO ONLY THOSE INDIVIDUALS EARNING LESS THAN 150 PERCENT OF THE FEDERAL POVERTY INCOME GUIDELINES. THEREFORE, A FAMILY OF THREE EARNING MORE THAN $15,840, WOULD NOT QUALIFY FOR "CHARITY CARE," EVEN IF THEY WERE FACED WITH A $50,000 BILL. THEY OBVIOUSLY WOULD BE HARD PRESSED TO PAY FOR A LARGE HOSPITAL BILL AND RELATED EXPENSES, AND OBVIOUSLY EVEN A SMALL BILL.

TO SUMMARIZE, SINCE THE STATE'S CHARITY-CARE INCOME-ELIGIBILITY REQUIREMENTS ARE SO STRINGENT, UNCOLLECTIBLE AND UNPAID BILLS ARE RARELY CLASSIFIED AS CHARITY CARE AND ARE ERRONEOUSLY CLASSIFIED AS BAD DEBT.

IN CLOSING, I WOULD LIKE TO THANK YOU, CHAIRMAN CODEY AND MEMBERS OF THIS COMMITTEE, FOR GIVING NJHA THE OPPORTUNITY TO TESTIFY TODAY. WE APPRECIATE YOUR INTEREST IN ATTEMPTING TO SOLVE SOME OF THE PRESSING HEALTHCARE ISSUES IN NEW JERSEY AND WE LOOK FORWARD TO LENDING OUR HAND IN DEVELOPING MEANINGFUL SOLUTIONS. THANK YOU.

STATE SENATE INSTITUTIONS, HEALTH & WELFARE COMMITTEE

NOVEMBER 14, 1990

CHAIRMAN CODEY, SENATORS, LADIES AND GENTLEMEN, THANK YOU FOR THE OPPORTUNITY TO PRESENT BLUE CROSS AND BLUE SHIELD'S VIEWS ON THE HEALTH CARE CRISIS WHICH IS UPON US.

THIS NATION HAS A CRISIS BEFORE IT. WE IN NEW JERSEY ARE IMMERSED IN THAT CRISIS. YET IN OUR CRISIS THERE IS OPPORTUNITY. IT IS AN OPPORTUNITY TO MAKE SUBSTANTIVE CHANGES TO BRING SOME STABILITY TO THIS CHAOS. OUR OPPORTUNITY IS BECAUSE GOVERNOR FLORIO APPOINTED AND RECEIVED A REPORT FROM HIS COMMISSION ON HEALTH CARE. THIS COMPREHENSIVE REPORT CALLS FOR INNOVATIVE ACTIONS THAT NEED TO BE IMPLEMENTED NOW.

SENATOR CODEY AS A MEMBER OF THE COMMISSION HAS PLAYED AN EXTRAORDINARY ROLE IN SEEING THAT DIFFICULT ISSUES ARE KEPT IN THE FOREFRONT. HIS WILLINGNESS TO PLACE THESE ISSUES BEFORE THE LEGISLATURE IN THESE TOUGH TIMES IS TESTAMENT TO HIS FORESIGHT AND UNDERSTANDING.

*IN NEW JERSEY WE ARE BEING OVERWHELMED PARTICULARLY BY COST-SHIFTING. ALTHOUGH WE HAVE BEEN SOCIALLY RESPONSIBLE IN NJ BY PROVIDING ACCESS TO HOSPITAL CARE FOR EVERYONE THROUGH THE UNCOMPENSATED CARE FUND, THE COST HAS GROWN FROM $80 MILLION TO NEARLY $1 BILLION IN LESS THAN TEN YEARS.

* ADDING SIGNIFICANTLY TO THAT PROBLEM IN THE FEDERAL GOVERNMENT'S RETRENCHMENT IN MEDICARE. THIS MEDICARE COST SHIFTING IN NJ WILL ADD ANOTHER $1 BILLION TO THAT PROBLEM BY 1992.

* THIS COST SHIFTING HAS BEEN PAID THROUGH A HIDDEN TAX WHICH FALLS MOST HEAVILY ON THE ORGANIZATIONS AND EMPLOYERS THAT PROVIDE

HEALTH INSURANCE. UNFORTUNATELY, MANY OF THOSE THAT PROVIDE HEALTH INSURANCE FAIL TO UNDERSTAND THAT THEY ARE ALREADY PAYING AN EXCESSIVE AND DISPARATE SHARE OF THE COST SHIFTING BURDEN.

* THE DRAMATIC INCREASE IN INSURANCE TO ACCOMMODATE THE COST SHIFTING AND STATE COST TRENDS THREATENS THE VIABILITY OF OUR SYSTEM BY INCREASING THE NUMBER OF UNINSURED TO OVER 800,000.

THE GOVERNORS COMMISSION ISSUED OVER 90 RECOMMENDATIONS INCORPORATING THEM INTO A 10 POINT PLAN. AS OUR CHAIRMAN DON DANIELS HAS STATED REPEATEDLY BLUE CROSS AND BLUE SHIELD ENTHUSIASTICALLY ENDORSES THE REPORT. FOR THE RECORD I HIGHLIGHT SEVERAL.

1. REFORM OF THE HOSPITAL RATE-SETTING PROCESS. IT IS TOO CUMBERSOME AND LABORIOUS FOR THERE TO BE VALID ACCOUNTABILITY.

2. INSTITUTE INSURANCE REFORMS TO BE SURE THERE IS A LEVEL

PLAYING FIELD FOR ALL INSURERS ESPECIALLY IN THE INDIVIDUAL MARKETS. ANY INSURER WHO WISHES TO SELL IN THIS MARKET SHOULD BE REQUIRED TO COMMUNITY RATE; SHOULD NOT MAKE A PROFIT AND SHOULD RETURN 80 CENTS OF EVERY PREMIUM DOLLAR IN BENEFITS. I CANNOT EMPHASIZE ENOUGH THE BENEFITS THAT WILL ACCRUE TO THE ENTIRE SYSTEM IF THESE REFORMS ARE INSTITUTED.

3. EXPAND MEDICAID LIMITS ALLOWED BY FEDERAL LAW AND ENROLL ALL MEDICAID RECIPIENTS IN A MANAGED CARE SYSTEM.

4. BIFURCATE BC/BS TO CREATE AN ENTITY FOR THE LARGE GROUP SECTOR, AND A NEW ENTITY TO SERVE THE PUBLIC POLICY SECTOR. THIS CLEARLY STATES THAT WE CANNOT OPERATE AS WE HAVE IN THE PAST.

THIS CONCEPT IS IN THE FORMATIVE STATE. TO ACCOMPLISH IT, LEGISLATION WILL HAVE TO BE DRAFTED TO CREATE A PUBLIC POLICY ENTITY TO PROVIDE HEALTH CARE COVERAGE, AS PRESENTLY DEFINED, FOR INDIVIDUALS AND GROUPS OF 10 AND UNDER; AND SIMULTANEOUSLY TO

CREATE A HEALTH INSURANCE ENTITY FOR LARGER GROUPS.

IT IS A SIMPLE EQUATION AFTER THAT: THE MORE PEOPLE WHO ARE COVERED, THE GREATER THE REDUCTION OF UNINSUREDS IN NEW JERSEY, AND THE MORE WE WILL BE ABLE TO REDUCE UNCOMPENSATED CARE -- PERHAPS THE SINGLE MOST TELLING REASON FOR THE HEALTH CARE CRISIS IN OUR STATE.

THERE ARE SIGNIFICANT ADVANTAGES AS WELL TO KEEPING THE PUBLIC POLICY ENTITY UNDER THE UMBRELLA OF A BLUE CROSS AND BLUE SHIELD HOLDING COMPANY.

FIRST, THERE IS THE UNIVERSAL ACCEPTABILITY OF THE BLUE CROSS AND BLUE SHIELD I.D. SECOND, THERE ARE THE DEEP DISCOUNTS AVAILABLE THROUGH THE BLUE CROSS AND BLUE SHIELD SYSTEM IN UTILIZING BENEFITS OUTSIDE OUR STATE.

PERHAPS MOST IMPORTANT IS THE FACT THE PUBLIC POLICY ENTITY WOULD

NOT HAVE TO BE SUBJECT TO THE SAME, STATE-MANDATED FINANCIAL RECOVERY PLAN UNDER WHICH BLUE CROSS AND BLUE SHIELD IS CURRENTLY OPERATING. IT MEANS LOWER PREMIUMS FOR THE INDIVIDUALS IN THIS POOL.

THERE ARE, HOWEVER, WAYS TO SUPPORT THIS PUBLIC POLICY POOL OF BUSINESS WITHOUT NEW TAXES. AMONG THEM ARE:

-- PROVIDING A SIGNIFICANT HOSPITAL DIFFERENTIAL OR DISCOUNT FOR INDIVIDUALS AND SMALL GROUPS, BASED ON A MEANS TEST.

--ESTABLISHING THE LEVEL PLAYING FIELD AMONG ALL CARRIERS FOR PUBLIC POLICY HEALTH INSURANCE.

--PERMIT THE OFFERING OF "BARE-BONES" COVERAGE, A REFORM WHICH WILL REQUIRE LEGISLATION TO EXEMPT SUCH COVERAGES FROM STATE MANDATED BENEFITS.

ON THAT LAST POINT, BLUE CROSS AND BLUE SHIELD HAS DESIGNED A "BARE-BONES" PRODUCT WHICH WILL PROVIDE BASIC HEALTH COVERAGE--INCLUDING 30 DAYS OF HOSPITAL CARE BENEFITS--FOR AN AVERAGE CONTRACT RATE OF $2,500 A YEAR, ABOUT HALF THE PRESENT RATES. BLUE CROSS AND BLUE SHIELD WILL FILE TO OFFER THIS COVERAGE IN ITS UPCOMING INDIVIDUAL RATE FILING.

OUR HEALTH CARE DILEMMA IN NJ IS MUCH LIKE THAT AT THE NATIONAL LEVEL. WE NOW HAVE A GOOD PLAN FROM WHICH TO BEGIN, BUT WE NEED LEADERSHIP TO AGREE THAT IT IS ESSENTIAL TODAY. OUR FEAR IS SIMPLY STATED THAT THESE PROPOSED REFORMS...IMPROVING THE DELIVERY SYSTEM, EXPANDING ACCESS, INCREASING INSURANCE COVERAGE, AND INITIATIVES NOT REQUIRING NEW FINANCING...THAT THESE MAY BE SIDELINED, SHELVED OR STUDIED BECAUSE OF THE PERCEPTUAL INABILITY TO ACT. THIS IMMOBILITY WOULD BE UNCONSCIONABLE FOR THE PUBLIC INTEREST AND SOCIALLY IRRESPONSIBLE. UNFORTUNATELY, SUCH INACTION MAY BE POLITICALLY FEASIBLE, BUT SHOULD NOT BE TOLERATED.

YOU ARE NO DOUBT AWARE THAT BLUE CROSS AND BLUE SHIELD IS PREPARING TO SUBMIT A VERY LARGE RATE REQUEST FOR INDIVIDUAL COVERAGES. WE MUST DO SO BECAUSE OF OUR FIDUCIARY RESPONSIBILITIES AND OBLIGATIONS UNDER THE 1988 RECOVERY ACT.

THERE ARE MANY PEOPLE WHO CANNOT AFFORD THE CURRENT RATES AND, UNFORTUNATELY, ARE GIVING UP THEIR HEALTH COVERAGE. THIS POOL OF BUSINESS HAS LOST OVER 13 PERCENT OF ITS SUBSCRIBERS IN THE FIRST NINE MONTHS OF THIS YEAR ALONE. NEW, HIGHER RATES WILL ONLY SPEED THE EXODUS.

THE NEW RATES ARE NECESSARY. BUT, THERE ARE ACTIONS THAT CAN SIGNIFICANTLY REDUCE THAT REQUEST BY ALMOST 20%. MOST OF THE REFORMS I HAVE MENTIONED--SPLITTING BLUE CROSS AND BLUE SHIELD, CREATING A LEVEL PLAYING FIELD FOR INDIVIDUAL COVERAGES, PERMITTING "BARE-BONES" OFFERINGS--WOULD REDUCE THE PENDING RATE INCREASE WITHOUT REQUIRING ANY GOVERNMENTAL FINANCIAL ASSISTANCE.

20%

IN TERMS OF URGENCY, I WOULD NOTE FOR THE COMMITTEE THAT THERE IS A WINDOW OF OPPORTUNITY TO IMPLEMENT THESE REFORMS TO HAVE AN IMPACT ON NEW RATES. THAT WINDOW, HOWEVER, IS ONLY A MATTER OF MONTHS--CERTAINLY A SMALL WINDOW INDEED IN TERMS OF SHAPING, ENACTING AND IMPLEMENTING PUBLIC POLICY. EACH MONTH OF DELAY WOULD INCREASE THE DEFICIT FOR THE INDIVIDUAL BOOK OF BUSINESS BY $12 MILLION.

I AM SURE YOU HAVE ALSO SEEN THIS MORNING'S NEWSPAPERS, AND ARE AWARE OF THE DEVASTATING IMPACT THIS HEALTH CARE CRISIS HAS HAD ON BLUE CROSS AND BLUE SHIELD OF NEW JERSEY AND THE PEOPLE OF NEW JERSEY.

YESTERDAY, WE COMPLETED A SIGNIFICANT DOWNSIZING AS A COST-SAVING MEASURE AND A STEP TO ALIGN OUR WORKFORCE WITH OUR CUSTOMER BASE. THESE MEASURES WILL RESULT IN BUDGET SAVINGS FOR 1991 OF $37 MILLION.

THESE STEPS ARE DIFFICULT, BUT NECESSARY--NECESSARY TO CONTINUE BLUE CROSS AND BLUE SHIELD'S PROGRESS TOWARD FINANCIAL RECOVERY AND TO ASSURE THAT WE REMAIN A VIABLE COMPANY, RESPONSIVE TO OUR CUSTOMER'S NEEDS.

THIS ALSO IS THE TIME FOR RESPONSIBLE PUBLIC ACTION. GOVERNOR FLORIO, SENATOR CODEY AND OTHERS HAVE PRESSED FOR THE TIMELY CONSIDERATION OF THE COMMISSION'S RECOMMENDATIONS. WE APPLAUD THIS INITIATIVE AND LEADERSHIP. AND WE LOOK FORWARD TO WORKING WITH THE LEGISLATURE IN RESOLVING THIS CRISIS.

FOR YOUR INFORMATION

Medical Society of New Jersey

HEALTH ACCESS NEW JERSEY

I. A plan proposed by the Medical Society of New Jersey to:

-- Ensure that patients have the ability to choose physicians, hospitals and health care plans;

-- Create incentives to make new technologies available;

-- Sustain an excellent medical education system;

-- Nurture high standards of conduct; and,

-- Reduce the need for defensive medicine.

II. Action to solve the uncompensated care crisis:

-- Expand access to care by raising Medicaid eligibility and increasing payments to individual providers.

-- Create a state operated health insurance pool for small businesses similar to the temporary disability program.

-- Foster health insurance risk pools to cover those who cannot obtain affordable insurance.

-- Eliminate health insurers' "pre-existing loss" requirement and waiting period for workers to gain coverage after changing jobs.

III. Medicine's role in reducing costs:

-- Encourage disease prevention and healthier lifestyles.

-- Require physicians to practice with the highest ethical standards.

-- Develop standard practice parameters for all specialties.

IV. Government's role in reducing costs:

-- Enact professional liability reforms to lessen the incidence of defensive medicine.

-- Eliminate the certificate of need requirement for diagnostic equipment, or alternatively, raise the dollar threshold to $2 million.

-- Redesign the hospital rate setting program to make it rational, understandable, and truly reflective of the actual cost of hospital care.

MEDICAL SOCIETY OF NEW JERSEY

HEALTH ACCESS NEW JERSEY
Position of The Medical Society of New Jersey
August 1990

I. INTRODUCTION

New Jersey is the most densely populated state in the nation. The standard of income and sophistication of our residents ranks among the top three states. Our health care system is among the finest. We have over 100 acute care hospitals, and our hospitals average over 300 acute care beds. For the most part, access to care is equitable throughout the state.

The University of Medicine and Dentistry of New Jersey is a nationally recognized medical school. Most areas of our state are within 30 minutes drive of major hospital and physician facilities, New Jersey residents have a variety of choices and immediate access to advanced technology and the finest clinicians in the world.

Beyond our technical capacities is an element of humane concern for all people, and a desire to assure that everyone has access to the care they need. In New Jersey, medical indigents as well as Medicaid patients have the same access to doctors and hospitals as the insured patient. Over $600 million yearly of hospital indigent patient services are funded by a surcharge on health insurers, while an additional $300-$500 million of physician services are provided voluntarily, without compensation, by the doctors of New Jersey.

It has been difficult, and is becoming more difficult, for the state and federal governments to properly fund Medicaid, and for providers to deliver care to the uninsured. The current program is institutionally focused and is very expensive. It lacks continuity of care, preventive medicine, and the dignity of delivery that our citizens deserve. It is possible that the current $2 billion operating budget can be re-directed to enhance both the quality and quantity of services so that hospitals are not used as physicians' offices.

Such a revision would place the Medicaid patient into the mainstream of health care. This would maximize efficiency and permit hospitals to concentrate on those patients whose severity of illness warrants hospital-based care.

Given the background of our environment, it is necessary to note that our current delivery systems, both ambulatory and inpatient, provide consistently high quality and reasonably priced services. A recent study by New Jersey Citizens' Action revealed

that the average United States citizen spends $2,251 yearly for health care, while New Jersey residents spend $1,643. New Jersey therefore is significantly below the national average, and only marginally ahead of the Canadian average of $1,515 per person. Economic factors, the complexity of society, and concern for the treatment environment differ dramatically between Canada and New Jersey, so the relative parity of these cost figures is remarkable.

While our system has done well, it is under stress. Care for the uninsured and the Medicaid patient must be funded in a more stable and equitable fashion. New Jersey citizens must be assured of access to care in an environment acceptable to the patient, the physicians and the hospitals. Physicians and hospitals must be allowed to function in an environment that permits professional freedom while requiring public accountability.

II. HEALTH ACCESS NEW JERSEY

The major thrust of the Medical Society of New Jersey and the physicians it represents is to search for ways to expand access to care for those persons in New Jersey who have no insurance or who lack adequate health insurance coverage, while seeking ways to reduce the spiraling cost of health care.

It is clear that some segments of our system in New Jersey need major restructuring. This restructuring needs to be accomplished in a manner that does not jeopardize access to quality care or strong aspects of our current system.

Health Access New Jersey presents a challenge to governmental forces in the state. The challenge is whether this administration is willing to pay for access to care for all those who cannot provide it for themselves. Certain priorities must be considered:

1. Revenues may have to be transferred between or among current programs.

2. New sources of revenue may have to be found.

3. Public support for legislation necessary to bring about concrete changes will have to be developed.

There is a need for statewide dialogue to address these changes and critical issues. The problems facing the New Jersey health care system cannot be solved by any one group -- Government or the private sector. A collaborative process should be pursued, with Government and medicine working together for the best interests of our citizens.

Certain conceptual elements must become governmental policy goals. These include:

1. Ensure that most patients have the ability to choose the physicians, hospitals, and systems of health care that they want and are comfortable with.

2. Create incentives to make available new technology.

3. Sustain a medical education system which seeks to attract the best and brightest students, leading them into a rigorous and comprehensive learning process that will assure the public of well-trained physicians in the future.

4. Nurture professional ethics, prudent judgment, and professional freedom in the delivery of health care to the citizens of New Jersey.

5. Take steps to reduce the reasons creating the need for physicians to practice defensive medicine.

III. HEALTH ACCESS PLAN -- NEW JERSEY

To accomplish Health Access New Jersey, several specific activities are needed.

Role of Government:

A. Increase access to care by enacting major Medicaid reforms. It is distressing that Medicaid is so abysmal. New Jersey should assure that all persons of low and poverty income levels are eligible for adequate benefits so that no poor person is left without access to needed health care. Perhaps a Medicaid eligibility standard of 185 percent of the federal poverty level could be a goal that will allow for coverage of most uninsured. All basic medical benefits must be covered. There should be no rationing of care nor skimping of funds. Physicians and hospitals should be paid fairly for services rendered to Medicaid patients, at least at the same rate the federal government pays for Medicare patients.

B. Create a state operated health insurance pool for small employers similar to the state operated insurance mechanism for temporary disability benefits. The thousands of small employers and their employees would comprise an underwriting pool of tens of thousands that could be effectively and efficiently insured.

C. Increase access to care by creating state level risk pools that would make available coverage for those who are unable to obtain affordable health care insurance. These pools would ensure that no one in New Jersey would be denied health care insurance because of a particular health condition. They would also guarantee continued health care coverage when persons are changing jobs.

D. Reduce health care costs through professional liability reform. This would reduce the practice of defensive medicine. It is estimated that defensive medicine adds approximately 15 to 25 percent to the total health bill. There are estimates that defensive medicine may approach $20 to $30 billion yearly in the United States, and perhaps more than $1 billion per year in New Jersey. Reform should be designed to lower frequency and severity of speculative litigation, while preserving the rights of injured patients.

Areas for a legislative approach may be:

1. Require a certificate of merit as a prerequisite to file a liability case.
2. Adoption of basic medical expert witness criteria.
3. Limitation of $250,000 on recovery of non-economic damages.
4. Periodic payment of future awards for damages.
5. Declaring a definite Statute of Limitations.

E. Develop professional practice parameters to help assure that only high quality appropriate medical services are provided. This will impact favorably on quality and cost of medical care. Such parameters would be professionally developed strategies for patient care, developed to assist physicians in clinical decision-making.

F. Urge more state, federal, and medical school support for medical education and research. We must increase state grants/scholarships to ease the widespread anxiety among medical students about their ability to finance their medical education. The accumulated debt of many students is overwhelming, and this is due largely to the fact that many students come from middle-to-low income families who cannot make substantial financial contributions to the education of their children.

G. We can reduce health care costs by reducing the administrative cost of health care delivery and excessive paper work forced onto patients, their families, and their physicians. The frustrations of physicians in dealing with differing managed care requirements of multiple insurance companies and Government programs result in increased office costs and interference with the physician /patient relationship.

Role of the Medical Community:

A. Encourage health promotion and disease prevention, including healthier life styles. We must promote programs that will eliminate smoking, decrease alcoholism and drug abuse, reduce cholesterol, encourage better adolescent health practices, and decrease the spread of AIDS.

B. Encourage physicians to practice with the highest ethical standards. We should encourage all physicians to:

1. Treat their patients as individuals.
2. Use best possible judgment in every case regarding quality of care.
3. Inform patients (when possible) of the usual risks, complications, and alternatives regarding health care, and the costs of such care.
4. Treat patients with courtesy, dignity, respect, compassion and attention.
5. Overcome bias in the treatment of AIDS patients.

C. Develop standard practice parameters for all specialties of medical practice.

IV. SPECIAL PROBLEMS

A. Uncompensated Care

1. Increase the Medicaid eligibility levels to 185 percent of the federal poverty level so that more persons are covered under Medicaid.
2. Provide state-operated insurance pools, so all employers can participate.

3. Eliminating the usual "pre-existing loss" requirement and the waiting period required by insurance companies would allow persons to have continued health care coverage when changing jobs.

B. Certificate of Need

The Certificate of Need Program (CON) should be re-evaluated. Our state has a hospital rate-setting mechanism which makes the CON program in its present form obsolete. Nationally, at least 12 other states have repealed their CON legislation as they developed rate-setting mechanisms. If, however, the state wishes to continue the program, modifications should be studied. Among the points to be considered are:

- Removing the requirement of a CON for diagnostic technology.
- In the alternative, raise the entry level for CONs from the current base of $400 thousand cost factor to $2 million.

There has been considerable speculation that the Governor and the Commission believe that the CON must be extended to physicians to create a level playing field. While the Society does not agree with that goal, it understands it but does not believe it can be practically or equitably achieved. Hospitals are multi-million dollar corporate conglomerates. They employ hundreds of people and retain batteries of lawyers, accountants, financial advisers, etc. The current CON system is dominated by hospital interests. Most of the persons in the approval cycle are either directly or indirectly (but very significantly) connected to hospitals.

Certificate of Need extension to physician offices clearly interferes with the physicians' ability to exercise their legally franchised right to practice what they in fact have been trained to do. As an example, the radiologist is trained and licensed to practice radiologic services, which may include all forms of imaging. Forcing such a physician to obtain a CON to practice his/her specialty in a private office setting is an improper intrusion and restriction of the physician's right to practice what he/she has been licensed to perform.

Further, the restrictive CON process now in place, particularly as it applies to diagnostic services, has fostered the proliferation of private imaging services because of demands for access to such services and the limited access in hospitals settings.

Therefore, in the context of a CON for physicians, the following must be addressed:

- There must be careful consideration as to when a CON is required. Everything that a doctor does in his office is also done by doctors in hospitals. The point of attachment needs to be selected with such concern so that it does not destroy the opportunity for the private practice of medicine, if we are to avoid a monolithic system.

- The decisional apparatus must be patently objective and cannot demonstrate the slightest appearance of impropriety. The current CON apparatus does not meet this test. Hospital interests are evident and controlling. Decisions will need to be insulated from undue influence, and those making the decisions cannot have a direct or indirect interest in the outcome. It is difficult to envision how the current composition of either the SHCC or the HCAB can meet the test of objectivity required. Either a new format or a reconstituted SHCC and/or HCAB must be used, with the appointees being full time governmental employees (other than those whose duties involve operating hospitals).

- Physicians must be granted fair, non-discriminatory, and equal access to controlled technology. If the state is to apply CONs to the physician community, then the recipient of CONs must be required to permit all physicians within the defined geographic region access to the equipment. If the equipment requires specialty designation or skills, it would be appropriate to require that physicians applying for "use" privileges demonstrate their qualifications.

- Application of current reimbursement rules that apply to hospitals granted a CON, which include extraordinary rate relief when the hospital faces bankruptcy in the operation of its services, must be extended to physicians who are subject to the CON process.

Summary

The CON process has neither contained costs nor produced maximum utilization of available health dollars. The CON system has been used to direct sophisticated technology to failing urban hospitals in an effort to stabilize their poor financial positions. This activity is neither compatible nor consistent with natural market forces. It has not been successful and is not likely to be successful.

Rather than focus on the CON as a planning method, the state should re-evaluate the concept and consider using a strategic planning model in its place.

C. DRGs

This system of payment to hospitals has proven to be inadequate, expensive, and should be eliminated. The federal government reportedly will be abandoning it in the next several years. Other states have more efficient and effective methods to finance hospital care than New Jersey. A study presented to the Health Department several years ago indicated that the "Share" system was just as effective and less expensive to manage in New Jersey.

A system is needed which is truly prospective and permits rapid decision making on the rate setting process. Hospitals should not be penalized for making rate review requests. However, the system should truly reward those hospitals that operate efficiently and penalize those that do not.

D. Medicaid

The Medicaid program in New Jersey has not provided quality care on a routine basis to recipients. The provider fee schedule is woefully substandard, and the federal Health Care Financing Administration has notified the state government that because of low provider reimbursement and its adverse impact on participation, the program is dangerously close to a declaration of non-compliance.

State administrators have not recognized the flawed approach of the substandard fee schedule and have not corrected it. Instead, they have concentrated for over 5 years on a managed care or HMO concept that has not been accepted by Medicaid patients or health care providers. What the Medicaid administrators have not recognized is that managed care is not a broad spectrum solution. It will only succeed when there are highly motivated patients, and highly motivated physicians.

The best course for Medicaid is a multifaceted system. A viable fee for service program must be offered and does have a place. Fee for service has never been given a chance, and it clearly deserves an opportunity to succeed.

Fee for service with realistic utilization controls provides cost effective, high quality services and assures access.

Managed care is not a panacea. In those instances where it is used, it must be monitored to assure that underutilization, lack of access, and loss of quality are not occurring.

E. Physician Self-Referral to Diagnostic Services

Physician self-referral to diagnostic services in which they hold an economic interest is an important issue being studied on both the state and federal levels.

Certainly if a service is considered essential to physician's specialty, it should be available through the physician. Cardiologists must, for example, have immediate access to x-ray, EKGs, and certain laboratory tests. Orthopaedists and physiatrists must have x-ray capability, and frequently do and should provide physical therapy, on site, under direct supervision. These instances are not all inclusive, but do demonstrate high quality, cost effective medicine.

Physician referrals to diagnostic centers in which they have an interest should be governed by advance disclosures to the patient with an option for the patient to go elsewhere. Hospital staff appointments are of significant economic interest to physicians. Physician referrals to the hospitals where they hold privileges are also subject to potential abuse, and must be carefully monitored.

F. Medicare Mandated Assignment

One of the major reasons for the rise in the cost of care is that the group of patients paying for services at regular rates is decreasing in ratio to the indigent, and those covered by Medicare and Medicaid. Senior citizens have pressed for mandatory assignment. Many seniors have significant incomes and assets. It is unfair to the non-government program patient to limit the liability of seniors who are well-off. A senior with a $25,000 annual income is far better off than a family of four with an income of $30,000.

Mandated assignment is unnecessary in light of federal law which limits balance billings to the federally-approved MAAC level. That level has consistently declined, and will be further reduced on January 1, 1991.

VI. SUMMARY

We feel these proposals will strengthen the New Jersey health care system. They present an enormous challenge for this administration and to all concerned. We welcome and encourage your support, and anticipate a long-term close relationship between Government and physicians, hopefully working together to bring about the best possible health care to all the citizens of New Jersey!

HEALTH COST DATA -- NEW JERSEY

$ 650	million	Uncompensated Hospital Care
$ 300-500	million	Uncompensated Physician Care
$ 150	million	Under-reimbursed Physician Care in Medicaid
$ 400	million	Hospital and Doctor Malpractice Premiums
$ 2	million	Auto Surcharge - Doctors
$ 2.5	million	Auto Surcharge - Medical Inter-Insurance Exchange of New Jersey
$ 2.5	million	Auto Surcharge - Princeton
$ 250	million	Medicare Undercompensation of Doctors
$ 1.757	billion	
$ 1	billion	(Estimated Defensive Medicine Cost)
$ 2.757	billion	Total
$ 5	million	Malpractice Surcharge - State JUA
$ 2.762	billion	

Conclusion: There are $ 2.762 billion being added to the cost of health care in New Jersey related to governmental policies that force cost shifts to private patients, and the failure of government to address professional liability reform.

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14 November 1990

To: Senate Committee Hearing
Re: Control of Health Care Costs

I would like to offer my observations and suggestions relative to the health cost crisis currently facing us. I draw upon my 27 years as a family physician, and my experience dealing with medical malpractice (as a member of the Board of Directors of N.J. State Medical Underwriters) and utilization review (as chairman of U.R. at JFK Medical Center in Edison.)

Solutions are being bandied about in the newspapers and in the legislative halls for <u>funding</u> of the health care deficits. However, the key to the solution is in controlling the <u>unnecessary</u> costs by addressing the causes of over-utilization of health care services.

The current health care system is being driven by the quest for diagnosis, rather than for therapeutic results.

NO SOLUTIONS WILL RESULT WITHOUT ADDRESSING THE ISSUES OF MEDICAL MALPRACTICE, DRG'S, AND OVERUTILIZATION OF SERVICES.

No physician gets sued for ordering a CAT scan or for doing a C-Section, only for failing to do so. The major cause of litigation is for "failure to diagnose." Some estimates go as high as one billion ($1,000,000,000) dollars a year being spent in New Jersey for <u>defensive medicine</u>.

The DRG system is completely diagnosis driven. Along with the new HCFA point system and the generic screen, this serves to drive medical costs skyward.

Over-utilization of medical, hospital, and diagnostic services, as well as over-use of drugs and supplies, are uncontrolled.

Therapeutic outcomes are neither recognized nor are they reimbursed under our current system, nor is the use of less costly medical care either rewarded or recommended.

MEDICAL MALPRACTICE FEARS AND BUREAUCRATIC CONTROLS DRIVE THE COST OF MEDICAL INSURANCE AND MEDICAL COSTS TO ITS CURRENT UNAFFORDABLE HEIGHTS.

I will comment further in my oral remarks.

Robert S. Maurer, D.O.

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Statement of the HEAL Coalition
Before the Senate Institution, Health and Welfare Committee
November 14, 1990

Mr. Chairman and Members of the Committee: we come before you today as members of the HEAL (Help Establish Affordable health care Laws) coalition, a group of small and large businesses representing the employers who provide jobs for more than three million New Jerseyans.

Our message is a positive one --- that all New Jersey residents should and must have access to health care. It is for this reason, as we will show later, that we are able to endorse much of what the Governor's Task Force on Health Care Costs recommended earlier this year.

However, we must reject the Commission's recommendation that the delivery of affordable health care makes necessary the imposition of employer taxes and penalties. First, to consider such a tax without knowing who is utilizing the Uncompensated Care Trust Fund is tantamount to writing out a blank check before we know the magnitude of the problem. It is, therefore, our recommendation that a provision mandating an audit of the fund should be included in any measure to extend the fund's existence.

Second, enactment of the reform measures we will describe should serve to lessen the dependence on the trust fund which was created to be a safety net for the uninsured.

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Finally, we must consider the extremely negative impact the imposition of yet another tax will have on our state's business community, especially the small employers, as they struggle to survive in this fast declining economy. It is certainly possible that enactment of a payroll tax and the so-called "play or pay" provision could lead to reductions in other employee benefits, the withholding of salary increases or even decreases in the labor force. Is it the responsibility of business to pick up the tab for affordable health care? We think that it is a societal responsibility for which our government should assume a greater responsibility.

Permit me now to ask that Hank Meisner of Prudential, a member company of the Health Insurance Association of America, to explain to you the reforms in the small group insurance market we are hoping to see translated into legislation and enacted as soon as possible.

SMALL GROUP INSURANCE REFORM

In recent weeks the possibility of mandating employer-paid health insurance has been discussed as one way to assure affordable and accessible health care. The HEAL coalition opposes this concept as a quick fix solution which could have a devastating economic impact.

As a viable alternative to mandated health insurance, the HEAL coalition has developed a proposed piece of legislation which we believe will stablize the cost of small group insurance and improve the availability of insurance, thus make it appealing to that segment of the business community currently priced out of the insurance market --- the small employer.

Allow me to briefly describe our proposal.

Chief among our bill's provisions is one which makes it a condition of doing business in New Jersey that all small group insurance carriers, Health Maintenance Organizations and Blue Cross/Blue Shield must issue a plan to any small employer (defined as those with 25 or fewer full-time employees) --- as long as they make the required premium payments and satisfy other provisions of the plan. And one of the two plans they must offer the small employer is one of basic, or "bare bones," health care coverage without costly state-mandated benefits. As you know, larger businesses which self-insure now operate without any required mandates.

In addition, the bill would eliminate pre-existing conditions that exist when an individual changes jobs or coverage. All small employer health benefit plans would be required to credit the time that person was subject to a pre-existing condition exclusion under the previous plan.

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The HEAL proposal, in an effort to stabilize now widely fluctuating premium costs in the small group market, would limit annual rate increases for any group to 15 percent of the carrier's lowest rate for a group of similar characteristics.

In addition, the legislation would require that the premium rates charged for any group not vary by more than 35 percent above or below the average premium rate for similar groups with similar coverage.

And the legislation would provide for the establishment of affordable small employer health benefit plans, including managed care features, to contain costs. Every small group carrier would be required to offer one of the approved plans, which will permit employers to make comparisons of premiums for identical products.

The cost and risk of covering high-risk groups and individuals would, under this proposal, be spread throughout the industry by means of a reinsurance mechanism. Participation in the reinsurance program would be voluntary, with small employer carriers having the additional option of internalizing all risks and costs. Carriers electing to use the reinsurance facility would be subject to assessments of up to four percent of their small group market to offset the facility's losses.

Let me make one thing clear about the reinsurance mechanism: it is not a JUA. The reinsurance program is designed to be attractive only to carriers with truly high-risk groups and individuals, with rates being set at 1.5 times the rates established for classifications or groups with similar characteristics or coverage. The JUA's rates, conversely, were held artificially low so as to make them attractive to even good drivers.

In summary, the small group reform legislation will solve the pre-existing conditions, wide rate variations, elimination of high risk individuals from small group policies and allow businesses to shop on price and service based on equal products. It is our recommendation that these reforms be implemented as soon as possible, which would have a positive effect on the Uncompensated Care Trust Fund without creating a financial burden on the taxpayers of the state. Let me now have HEAL co-chair Maureen Lopes, Vice-president of Health Affairs for the New Jersey Business and Industry Association and a member of the Uncompensated Care Trust Fund Advisory Committee, describe our proposals related to the reform of this fund.

UNCOMPENSATED CARE TRUST FUND REFORM

As was stated by our first speaker, any reform of the Uncompensated Care Trust Fund must begin with an audit to determine the characteristics of the patients whose care is paid for through the trust fund. This collection of demographic data should then be done on an ongoing basis to permit a periodic review of the patients' characteristics o. We would ask that the Legislature work with the Department of Health and the New Jersey Hospital Association to determine the most cost effective way in which to make this data available for analysis in the future.

Hospitals must also be given incentives to improve their bad debt collection. We suggest that each year the Department of Health determine prospectively the amount of funding each hospital will receive from the trust fund for reimbursement of its charity care and bad debt. A hospital specific funding level would be determined by a predictive model which would include such factors as (a) the bad debt ratio among peer hospitals; (b) the unemployment rate in the hospitals' service areas; (c) the hospitals' increase in total revenues; and (d) patient income levels and insurance status. The data obtained from the completion of the audit will better define the key variables.

Once its uncompensated care level was established on an annual basis, a hospital would be required to institute credit and collection procedures necessary to function within this level. As a safety net for any hospital which experiences a significant shortfall in uncompensated care funding, the Hospital Rate Setting Commission could undertake a full rate review.

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In addition, we would strongly support the recommendation by the Governor's Commission that county and/or state Medicaid workers be placed on-site at community health centers and hospitals serving large indigient populations to facilitate eligibility determinations.

Our final proposal in this area would expand reimbursment from the uncompensated care fund to non-hospital providers. Specifically, we would support using up to one percent of the UCTF to fund pilot projects aimed at reducing the need for the fund. One such project to encourage small business to provide health insurance has already been designed through a task force within the Department of Health. Funding should, moreover, be provided for projects which form partnerships between hospitals which have a high percentage of emergency room primary care cases and local community health centers to determine if the system as a whole would save money if emergency room usage decreased.

We would now ask HEAL co-chair Melanie Willoughby, President of the New Jersey Retail Merchants Association, to decribe the final portion of our proposed legislative package dealing with the Medicaid program.

MEDICAID REFORMS

The most optimistic expansion in the purchasing of health care insurance could occur and yet we know that there would remain some people who are uninsured. Some would be low-income workers and their dependents who cannot afford to purchase their own health coverage. Others are "uninsurable" due to chronic illness. Still others will be without insurance while they are temporarily unemployed.

We believe expanding and revising portions of our Medicaid system should result in more of the state's low-income uninsured receiving health coverage.

The first provision of HEAL's proposed Medicaid reform legislation would --- as the Governor's commission suggested --- extend Medicaid to include all persons who fall below the poverty level, irrespective of age, disability, family or employment status. Most of New Jersey's poor and near poor who are not covered by Medicaid must now rely on the uncompensated care fund. If they were to be brought under the Medicaid umbrella, matching federal funds would be available also.

We also propose that an HMO-type program should be established to provide medical care to individuals within Medicaid programs. With financial support from both state and federal governments, such a program would provide recipients with high-quality care through a primary-care provider, rather than relying on more expensive emergency room or inpatient care treatment.

-MORE-

A Medicaid Buy-In program is another component of the HEAL proposal. Under this concept, people with incomes of less than 50 percent above the poverty level --- and with limited assets --- would be permitted to buy coverage for a limited set of non-hospital primary and preventive services at a premium cost based on their ability to pay. This program would (1) grant the near-poor access to the care that now most must forego; (2) "fill-in" in front of private plans for near-poor persons who also have private coverage; and (3) avoid costly government substitution of public coverage for private coverage. As a temporary measure, this type of "buy-in" program could also be extended below the poverty line if fiscal realities in New Jersey make impractical the provision of a complete range of Medicaid services.

Our final suggestion in this area is the establishment of a Medicaid "Buy-Out" program where the near and working poor would be encouraged to use employment-based coverage and the state would pay a portion of the worker's share of this private coverage. Contributions toward premiums, deductibles and co-payments would be included as it was in the recently enacted Connecticut Medicaid law.

In closing, we believe that Medicaid reforms present an important opportunity for the public sector to meet the needs of the uninsured. Funding from Medicaid, coupled with private-sector reforms, are elements key to a comprehensive resolution of our health care crisis.

NEW JERSEY STATE
CHAMBER OF COMMERCE
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Statement of the New Jersey State Chamber of Commerce

Presented by:

James C. Morford, Vice President, Governmental Relations

Public Hearing of the Senate Institutions,
Health and Welfare Committee

November 14, 1990

Senator Codey and members of the Committee, the New Jersey State Chamber of Commerce is pleased to offer comments on the recently released report of the Governor's Commission on Health Care Costs. The State Chamber, along with its affiliated local & regional Chamber's of Commerce represents more than 45,000 businesses throughout our state.

As you know, the New Jersey State Chamber of Commerce has expressed very deep reservations about some of the specific points in the report of the Governor's Commission, specifically the proposed payroll tax, and the health insurance mandates or penalties, commonly known as "pay or play."

The State Chamber stands for cost controls anchored by managed care and small group policy reforms, with all "players" participating; business, labor, government, hospitals, doctors, insurance providers -- all share in the problem, and all have a stake in the solutions.

The debate on the issue of health care delivery is one that has been driven by the spectra of rapidly rising costs, costs that for the most part have been absorbed by the business community. Some pressure is also being felt by our state's largest labor unions, particularly those who cover the costs for their members. These particular labor organizations share a common concern with the majority of businesses who bear the costs for providing health insurance for their employees.

At present, nine out of 10 full-time workers in the state are covered by health insurance. It is disappointing,

therefore, that throughout this debate, the business community, especially the small business operators of our state, have been cast as the "bad guys," especially those who have yielded to overwhelming financial pressures and either dropped health insurance coverage, or scaled it back. Many small business owners reached that decision only when it came to choosing coverage for their employees, or folding the businesses they've worked so hard to establish.

Most small businesses that don't provide health insurance for their employees have made that decision because of the cost. Mandated health insurance coverage will serve to drive more small business owners to close or relocate outside of New Jersey. The result could very likely be an increase in unemployment and additional drains on the Uncompensated Care Trust Fund.

The State Chamber is deeply concerned over the proposal of the Governor's Commission to impose a payroll tax. At the very least such a proposal is premature. Without instituting needed reforms in our health care delivery system the imposition of a payroll tax would clearly be a case of "putting the cart before the horse."

Before imposing a new tax let us consider ways to control costs. We would get a clearer picture of who are the users through an in-depth audit of the Uncompensated Care Trust Fund. Other reforms that the State Chamber recommends include:

- encouraging cost-effective managed care programs in both public and private health care plans and Medicaid.

- a series of small group market reforms, designed to provide accessible and affordable health care coverage for small business

- establishment of a voluntary basic health care policy, free from state legislated mandates

- expansion of Medicaid eligibility to access federal matching dollars

- setting additional standards for UCTF reimbursement

- allowing for reimbursement of medical care outside hospitals, to stem the use of expensive emergency room treatment.

We urge that the Uncompensated Care Trust Fund be extended for 18 months under its present, albeit unsatisfactory, funding system. That extension must be accompanied by reforms.

When we can evaluate or even estimate the impact of the reforms we propose then and only then will it be appropriate to consider funding alternatives to the present system.

While there are those who with great vigor and emotion advocate the opening of yet another business tax vein we must resist with equal vigor a proposal which would use the payroll tax to fund not only a renewed Uncompensated Care Trust Fund but add additional programs. Those additional entitlements, including some currently funded by State general revenues, are listed as "goals" in the Governor's Commission Report:

They are:

- Increased subsidization of insurance coverage, up to 300% of the federal poverty level.

- payment for treatment of AIDS patients

- establishment of a local health planning mechanism, and its attendant administration

- expansion of wellness care programs for all children up to age 17

These programs, while laudable in intent, will cost a great deal of money. By conservative estimates the annual pricetag would be more than $350 million on top of what is to be paid currently and prospectively for the Uncompensated Care Trust Fund.

Some very well intentioned people urge you to enact the payroll tax now and penalize those recalcitrant business owners who refuse to provide health insurance. But once this new revenue source is open and without prior reform of the system how do we stem the flow to meet ever increasing demands? Where's the tourniquet?

Again, put reforms in place FIRST, then let's talk about alternatives to the funding mechanisms.

The Legislature itself has a critical role to play in setting the tone for health care cost containment. One of the primary factors in the rapidly expanding cost of health insurance is mandated benefits. They represent upwards of 10% of the premium dollar. Yet, even as we meet here today to consider the dire condition of our state's health care delivery system there are at least six active bills under consideration in the Legislature that would impose new mandated coverages. Of course, each proposed mandate is a worthy cause but each would add to the cost of providing health insurance.

We agree with the public policy that no individual should be denied access to health care because he/she cannot demonstrate an ability to pay. It's a policy that is beneficial to all New Jerseyans. However, the State of New Jersey should not shy away from its own stake in this policy. Instead of trying to pass on more of its responsibility to provide for its citizens through a new business tax the State should commit a greater portion of its general revenues to fund this commitment. At present, we feel the state has made the promise, then handed the business community the "pledge card" - through increased costs, more mandated coverages and now a payroll tax with added penalties for those who do not provide health insurance.

We've heard many persons, both in the public and private sector, urge that health care be a priority of our state government. We agree, and setting priorities for state funds has been a recurrent theme in State Chamber testimony to the Joint Appropriations Committees. We believe that after enactment of our proposed reforms, the State will have adequate resources to fund that commitment. And if it does not that will be the time to consider alternatives.

The New Jersey State Chamber of Commerce thanks you, Mr. Chairman and Members of the Committee, for the opportunity to offer comment on the report of the Governor's Commission on Health Care Costs.

LOCAL HEALTH PLANNING AGENCIES
MAKE A DIFFERENCE

The 1971 New Jersey Health Facilities Planning Act established as public policy that no health care facility or service should be implemented unless it contributes to the orderly development of adequate and effective health care services. Since 1971, the public's right to know and have some say in the orderly and acceptable development of hospital, nursing home, and other health care services has been manifested in local area health planning agencies. As recently as May, 1987, this public right was reaffirmed by State Law P.L. 1987, Chapter 118. The new law established a New Jersey specific local health planning program with a requirement that each agency be governed by volunteers and funded at 12 cents per capita.

One only has to review the extensive examination of local health planning that took place prior to passage of P.L. 1987, Chapter 118 to comprehend its value.

On December 4, 1986, the Assembly Health and Human Resources Committee held a Public Hearing "To examine the Health Planning System in New Jersey". Sixteen agencies, organizations, provider associations, and individuals presented testimony. All of these diverse groups testified that health planning was needed.

On January 30, 1987, the Report of the State Blue Ribbon Task Force on Local Health Planning was issued. It concluded that the State of New Jersey needs to "...assure the residents of New Jersey that the local planning process would remain a viable and productive part of the overall system". The membership included representatives of private business (e.g. Atlantic Chemical, The Bergen Record, NJ Business Group on Health), hospital and nursing home providers, insurers, and the State Department of Health.

On March 12, 1987, after hearings by both the Assembly Appropriations Committee and Assembly Health and Human Services Committee, the full Assembly approved the local health planning agencies legislation by a 72-0 vote!

On March 26, 1987, the Senate concurred and voted approval by a vote of 32-1!

On May 7, 1987 the Governor signed P.L. 1987, Chapter 118 into law!

Local health planning agencies are an "integral component" of the Commissioner of Health's decision making process relative to Certificate of Need applications. Local health planning agencies provide assurance to the public that community concerns and priorities are advocated at the state level prior to a final decision being made. More importantly, the local health planning agency involvement in the Certificate of Need process makes a difference in the public trust for our state officials. No where did this become more evident than in early 1988 when the local health planning agency was by-passed by state officials and a new nursing home in northern New Jersey was approved without the required local review. The subsequent public outcry led to a court remand which stated, "...omitting the (local health planning) agency from the permitting process was particularly serious.". This reaffirmed the necessity of local health planning agency review for siting future facilities. A return to the orderly process in 1989 resulted in two new AIDS facilities approved in central New Jersey after extensive public input. Even though there was similar public objection to the proposals, the community as a whole felt they had a fair and full opportunity to express their views.

Perhaps of more significance were the findings of a seven month investigation by the State Attorney General's Program Integrity Section into allegations involving favoritism in the awarding of Certificates of Need. The report, issued in December 1988, contained this conclusion:

> "This investigation has confirmed that the process for reviewing Certificates of Need, when followed, provides a system of checks and balances which would made it difficult for any applicant or any government actor within the system, to dominate the process. Specifically, the review procedures entail many different levels, and thus depend upon the recommendations of many different actors. In addition, each actor within the process is held accountable for his or her recommendation and is expected to justify the recommendation based on objective criteria."

As New Jersey entered the 1990's, local and state health planning was reviewed for the fourth time in the past five years. This time by the Governor's Commission on Health Care Costs. In their October 1, 1990 report, CARE for New Jersey, the Commission affirmed that local health planning should continue in the form of Local Advisory Boards, as successors to the health service area (HSA) agencies.

It is clear the public's right to know and have some say in the orderly development of health care facilities and services has once again been objectively determined as valuable and necessary. The next logical step is to transition, without disruption of local input, from the HSA's to the LAB's.

Prepared by:
E. J. Peloquin
Executive Director
Central Jersey Health Planning Council
November, 1990

50 State Results of
Question That Asked Medicaid
Agencies When They're Going
to Implement Expansion

	1a. current Medicaid elig. level (women in Medicaid for full pregnancy)	1b. When expect to raise elig. to 133% of Fed. poverty level	1c Approval sought from HCFA for this delay? Y/N	1d Approval Granted? Y/N	2a # of additional pregnant women eligible?	2b # of additional pregnant women enrolled?	2c # of additional infants eligible?
bama	133	N/A	N/A	N/A	?	4500	?
ska	133	N/A	N/A	N/A	?	541	?
zona*	140	N/A	N/A	N/A	968	600	323
ansas	133	N/A	N/A	N/A	2990	?	2990
fornia	185*	N/A	N/A	N/A	N/A	N/A	N/A
rado	133	N/A	N/A	N/A	?	2868	?
ecticut	185	N/A	N/A	N/A	N/A	N/A	N/A
ware	133	N/A	N/A	N/A		548/yr	
	185	N/A	N/A	N/A	N/A	N/A	N/A
ida	150	N/A	N/A	N/A	N/A	N/A	N/A
gia	133	N/A	N/A	N/A	?	7,937*	?
aii	185	N/A	N/A	N/A	N/A	N/A	N/A
ho	133	N/A	N/A	N/A		3,010*	
ssis	133	N/A	N/A	N/A	3,810	2,449*	6,762
iana	133	N/A	N/A	N/A	7,400	6,500	7,400

51X

	1a Current Medicaid elig level - women & infants: % age of Fed. poverty level)	1b When expect to raise elig to 133% of Fed. poverty level?	1c If there has been a delay, was a waiver sought from the HCFA?	1d Approval Granted?	2a Resulting # of additional pregnant women eligible?	2b # of additional pregnant women enrolled?	2c # of additional infants eligible?
wa	18	N/A	N/A	N/A	N/A	N/A	N/A
sas	150	N/A	N/A	N/A	N/A	N/A	N/A
tucky	185	N/A	N/A	N/A	N/A	N/A	N/A
siana	133	N/A	N/A	N/A		2,555	
ne	185	N/A	N/A	N/A	N/A	N/A	N/A
yland	185	N/A	N/A	N/A	N/A	N/A	N/A
achusetts	185	N/A	N/A	N/A	N/A	N/A	N/A
igan	185	N/A	N/A	N/A	N/A	N/A	N/A
sota	185	N/A	N/A	N/A	N/A	N/A	N/A
ssippi	185	N/A	N/A	N/A	N/A	N/A	N/A
ouri	133	N/A	N/A	N/A	5500	3422	5500
ana	133	N/A	N/A	N/A		780	
aska	133	N/A	N/A	N/A		1375*	
ada	133	N/A	N/A	N/A		*	
Hampshire	133	N/A	N/A	N/A		*	

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EFFICIENCY LINE = 22 210

	1a Current Medicaid elig. level-women & infants (% age of Fed. poverty level)	1b When expect to raise elig. to 133% of Fed. poverty level?	1c If there has been a delay, was approval sought from HCFA?	1d Approval Granted?	2a Resulting # of additional pregnant women eligible?	2b # of additional pregnant women enrolled?	2c # of addl. infant eligible
New Jersey	100	4-1-91	Yes		1,132		1,132
New Mexico	133	N/A	N/A	N/A		630	
New York	185	N/A	N/A	N/A	N/A	N/A	N/A
N. Carolina	185	N/A	N/A	N/A	N/A	N/A	N/A
N. Dakota	133	N/A	N/A	N/A		614	
Ohio	133	N/A	N/A	N/A	13,000		
Oklahoma	133	N/A	N/A	N/A		2700	
Oregon	133	N/A	N/A	N/A	1,592/mo	972	
Pennsylvania	133	N/A	N/A	N/A		14,600	
Rhode Island	185	N/A	N/A	N/A	N/A	N/A	N/A
S. Carolina	185	N/A	N/A	N/A	N/A	N/A	N/A
S. Dakota	133	N/A	N/A	N/A		400	
Tennessee	150	N/A	N/A	N/A	N/A	N/A	N/A
Texas	133	N/A	N/A	N/A		849 *	
Utah	133	N/A	N/A	N/A		1,000	

EFFICIENCY LINE = 22.210

	1a Current Medicaid elig. level-women & infants (% age of Federal poverty level)	1b When expect to raise elig. to 133% of Fed. poverty level?	1c If there has been a delay, was approval sought from HCFA?	1d Approval Granted?	2a Resulting # of additional pregnant women eligible?	2b # of additional pregnant women enrolled?	2c # of additional infants eligible?
1							
2 Vermont	185	N/A	N/A	N/A	N/A	N/A	N/A
3							
4 Virginia	133	N/A	N/A	N/A	102 *	102 *	102
5							
6 Washington	185	N/A	N/A	N/A	N/A	N/A	N/A
7							
8 West Virginia	150	N/A	N/A	N/A	N/A	N/A	N/A
9							
10 Wisconsin	155	N/A	N/A	N/A	N/A	N/A	N/A
11							
12 Wyoming	133	N/A	N/A	N/A	.	800	
13							
14							
15							
16							
17							
18							
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US HEALTHCARE

Recommendations for Reform

of the

Health Care Delivery System

in

New Jersey

Presented to the
Governor's Commission on Health Care Costs
August 9, 1990

CORPORATE HEADQUARTERS
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I. Executive Summary

The Governor's Commission on Health Care Costs is facing serious challenges as its members work on reform of the New Jersey health care delivery system. The U.S. Healthcare proposal is offered to the Commission in the spirit of cooperation, to assist them in finding answers to the problems.

Approach to Reform

Reform should come by first assessing the current situation, and then making changes that will lower the costs of health care in the system. Following the implementation of those changes should come new programs for the uninsured. This is contrary to the approach many Commissions and Councils have taken, which create elaborate programs for the uninsured but have no way to finance them.

Structure of the Delivery System

The current employer-based system of access to health care for New Jersey residents should not be changed. There should be an emphasis on strengthening the business environment and reducing barriers to employer offering of health benefits. Incremental changes throughout the system can produce significant cost savings and revenue.

Quality Measurement for Cost Containment

The institution of measurements of quality as the basis of the health care system will reduce health care costs. Quality measurement is a mechanism that will reduce unnecessary and inappropriate medical procedures, and thereby contain costs.

Key Components of the Delivery System

A health care delivery system that is successful in the achievement of high quality health care while containing costs must contain six key components. These are:

1. Economic incentives in a competitive atmosphere.
2. Careful selection and recertification of providers.
3. The assessment of clinical capabilities of providers.
4. Stringent monitoring of care at all stages.
5. Systemic tools that payers need to keep costs lower.
6. Education of the consumer and employer.

HMOs as Primary Health Care Delivery Method

Health Maintenance Organizations integrate all of the six key components into a single, integrated system, and offer the greatest potential for New Jersey residents to receive the highest quality care, most appropriately given and on a cost-effective basis. Basic elements of HMOs - utilization review, outcomes research, development of practice guidelines, systems for the reduction of inappropriate and unnecessary care, pre-admission certification of inpatient hospital care and provision of care in the most appropriate setting - encourage high quality and cost-effective care.

HMOs use competitive contracting to contain costs and negotiate fair prices for consumers. The providers of the HMO must be certified according to stringent criteria to participate in the HMO network, and in some companies, recertified annually to continue to offer services.

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HMOs are involved with members' care at all stages, from the use of wellness programs to encourage health lifestyles to inpatient hospital care to the provision of home care as necessary.

State Coordination of Health Care

A high-level Council in state government should be formed to coordinate all of the elements of the New Jersey departments which affect health care delivery, to increase the system's efficiency, develop and coordinate the cost containment efforts and monitor programs for both cost containment and quality.

The Council's functions could include, but not be limited to, the coordination of the Certificate of Need process throughout all departments; the development and implementation of health care demonstration projects; the review and monitoring of provider reimbursement rates; the assurance of integration of provider payment charges with insurance premiums; the development of quality standards for providers; the development of a comprehensive data base for consumer use and policy making purposes; and the recommendation of health care delivery policy changes to the Governor.

Adopt Revised HMO Law

This proposal urges the passage of a revised HMO law, to meet the contemporary needs of both employers and consumers, and to assist HMOs in meeting the goal of providing access to cost-effective, high quality health care.

A new HMO law could broaden the powers of HMOs, prohibit balance billing of HMO members by physicians and hospitals, prohibit billing of HMO members for medical services covered by their HMO policy and provide incentives for providers to negotiate competitive rates with HMOs.

Repeal DRGs as Basis for Hospital Payment

The present system of basing payment for hospital costs on DRGs has not met the expectations surrounding its passage, and the primary recommendation is to repeal the law and create an unregulated, competitive system.

One major effect of the DRG system has been a significant increase in hospital rates for U.S. Healthcare members in New Jersey. From 1986 through 1989, per member per month costs in southern New Jersey and northern New Jersey increased 91.6% and 135.7%, respectively. For U.S. Healthcare members, southern New Jersey's per case payments are 40% higher than for members in southeastern Pennsylvania. In northern New Jersey, per case payments are about 9% higher than New York City's payments.

The DRG system is complex and confusing, and has led to delays in effective implementation. DRG payments are not directly related to the actual cost of services used, but are indirect estimates for a broad category of medical procedure. This results in higher consumer payment than necessary. In addition, DRGs do not create incentives for hospitals that want to increase their volume of patients by negotiating with HMOs for competitive rates.

Reform of Hospital Payment System

If DRGs are retained as the method for hospital payment, the system requires substantial reform to achieve cost savings and high quality of health care. Real reforms are needed to assist this system in fulfilling its expectations.

1. Implement methodology for reimbursement through detailed statute, rather than regulation, to create greater accountability and allow more public and payer access.

2. Make DRGs truly prospective, with rates set and effective for a fixed period of time, to counter problems of instability and uncertainty which are now prominent.

3. Establish standards of efficiency, cost and quality for hospitals and require that they be met as a condition of reimbursement.

4. Increase the manner and method of public and payer access into the hospital reimbursement system.

5. Integrate payment to hospital-based doctors into total hospital payment, to take away the monopoly effectively granted them and increase cost savings.

6. Make all hospital costs volume variable and require maintenance of volume of services, to reduce subsidization of inefficient operations.

7. Establish standards of quality and cost for the Certificate of Need process, and require that they be met before granting the privilege of offering a service to the consumer and at intervals throughout the time the service is offered.

8. Develop system of Performance Reports on providers, that would be made available to the public, and would be integrated into the Certificate of Need process.

9. Prohibit hospitals from shifting Medicare payment "shortfalls" to consumers and employers through private payers.

Physician Services: Billing Practices

Although not a practice of all physicians, some continue with the practice of accepting payment from a third party payer or Medicare for a determined amount and then billing an individual patient for the remainder. This practice, "balance billing," defeats the cost-saving effect of negotiated rates, and is an abuse that should be ended.

Another practice of some physicians is manipulating Current Procedural Terminology (CPT) Codes to falsely increase reimbursement. The "exploding" bill uses CPT codes to bill for the separate components of a medical procedure - which raises the cost - instead of the code assigned to the procedure as a whole. It is a practice that should be deemed fraudulent and prohibited.

Mandated Benefits

Requiring coverage for all possible health problems increases the cost of health care. Mandating benefits has a multiplier effect: first, the added cost for more expensive procedures; second, higher health benefit premiums to cover that cost, and third, fewer employers able to purchase health care coverage.

Establishing a minimum package of benefits that insurers must cover, and then permitting insurers to offer more comprehensive packages for competitive reasons, would expand the opportunities for access to health care.

Medicaid and the Uninsured

The medicaid program in New Jersey has much opportunity for expansion to meet the needs of medicaid recipients, and the elements of managed care can play an important role.

And finally, a goal of the Commission should be to lower the numbers of uninsured persons, through the enactment of significant reform of the costly elements of the delivery system and lowering the cost to employers to offer health benefits. Then, once that number is lowered, to enact a revised method of financing care for those persons.

II. Summary of Recommendations

Principles for a Successful Delivery System

No major structural changes in the health care delivery system.

1. **Maintain the current system of employer-based health benefits coverage.**

Establish key components for quality and cost containment.

1. **Economic incentives in a competitive atmosphere.**
2. **Careful selection and recertification of providers.**
3. **Assessment of clinical capabilities of these providers.**
4. **Stringent monitoring of care at all stages.**
5. **Systemic tools that payers need to keep costs lower.**
6. **Education of the consumer and employer.**

Establish HMOs as the primary health care delivery method.

Specific Recommendations for Implementation

Create a High Level Council in State Government to Coordinate the Health Care Delivery System.

Adopt a revised, updated HMO law to meet modern needs of employers and consumers.

Modify Method of Hospital Payment:

- **Primary: Repeal DRGs as basis for hospital payment and create an unregulated, competitive system.**
- **Secondary: If DRGs are kept, or if system remains regulated, then make substantial changes to improve payment methodology.**
- **Implement methodology for hospital reimbursement through detailed statute rather than regulation.**

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- If DRGs are kept as the basis for hospital payment, make the system truly prospective with rates set and effective for a fixed time period.
- Base hospital reimbursement on attainment of efficiency, cost and quality standards.
- Allow greater public and payer access into, and information on, reimbursement system.
- Make all hospital costs volume variable and require hospitals to maintain specified volume of services.

Integrate payment to hospital-based doctors into total hospital payment in recognition of the effective monopoly granted them and create incentives for cost savings.

Create incentives for state licensed HMOs to negotiate contracts with hospitals that include hospital-based physicians in per diem rate.

Revise Certificate of Need (CON) Process for uniform application, to add monitoring oversight, and to ensure that only cost-effective and high quality facilities, services, or equipment are permitted into the delivery system.

Require as condition of receiving and maintaining the privilege to have equipment or service, the demonstrated adherence to high quality standards by developing Performance Reports for Providers.

Prohibit hospitals from shifting Medicare payment "shortfalls" to consumers and employers through private payers.

Prohibit physicians from billing individuals in excess of a fee that they have agreed to accept from a third party payer or Medicare.

Prohibit physicians from unbundling or "exploding" bills to falsely increase reimbursement.

Establish a minimum set of standard health benefits:

- Primary: End all state requirements for mandated benefits beyond a minimum benefit level.

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- Secondary: Establish a minimum benefit package that must be offered by those insurers who offer benefits, but allow insurers to offer a greater package.
- Require any new mandated benefit proposed in the legislature to undergo a cost-benefit analysis, with payer and public comment solicited.
- Allow any newly established mandated benefit to be implemented only one time per year and allow immediate insurance premium rate adjustments.
- Assemble a panel of experts to make the determination of what should be an experimental or investigative procedure, and give the Commissioner of Health authority to develop guidelines and regulations.

Revise and Expand Medicaid Program:

- Expand Medicaid eligibility.
- Create open, competitive market system where Medicaid recipients are given vouchers to use for selection of private insurers that meet state determined levels of quality.
- Establish quality and cost standards for providers for certification and annual recertification as condition of participation in Medicaid Program.
- Develop incentives for private HMOs to enroll Medicaid recipients.

Revise the system for "Uncompensated" Care:

- Require hospitals to absorb a portion of the cost of care for the uninsured as a condition of maintaining tax-exempt status.
- Finance hospital bad debt for the Uninsured with a pool of funds from a hospital surcharge, and a tax on not-for-profit hospital real property.
- Require hospitals to establish community outreach programs to prevent high cost emergency room use by Medicaid and uninsured residents as condition for tax-exempt status.
- Designate specific hospitals in multi-hospital cities as facilities for indigent care.

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III. Opening Statement

While the Commission on Health Care Costs faces serious challenges, it also has the exciting opportunity to shape a health care delivery system that will open access to health care for more New Jersey residents. The Commission also has the opportunity to build effective cost-containment mechanisms into the system that are critical to ensuring the continuing availability of health care, and at the same time, to implement programs that will provide the highest quality medical care.

Many Commissions and Councils throughout the United States have already attempted this formidable challenge, and many still continue in their deliberations. But essentially, most have failed because in their approach and in their final products, they have recommended extensive new programs to provide access to health care **for which there is no present financing and no discussion of future financing mechanisms.** This approach is demonstrated in Chart #1 on the following page.

The approach must be reversed.

Access is not simply developing comprehensive new programs or mandating new insurance benefits. Expanding access begins by assessing the current situation and fixing that first. Although 37 million Americans are not receiving the best possible health care, over 150 million Americans are benefitting from the system. In New Jersey, the majority of the population is insured under the current system.

A successful reform plan must begin by lowering the costs of health care in the system as it is today. The equation is simple: If the cost of providing health care is lower - hospital costs, physician costs, administrative costs, technology and equipment costs - more employers will be able to afford to purchase insurance, and upgrade the insurance they already offer. When these numbers grow, the numbers of uninsured and underinsured drop. The result: A lowering of uncompensated care costs. High health costs, after all, ar a major cause of increase in the number of people who can no longer afford health care. This approach is demonstrated in Chart #2 on page 11.

CHART #1

OTHER APPROACHES

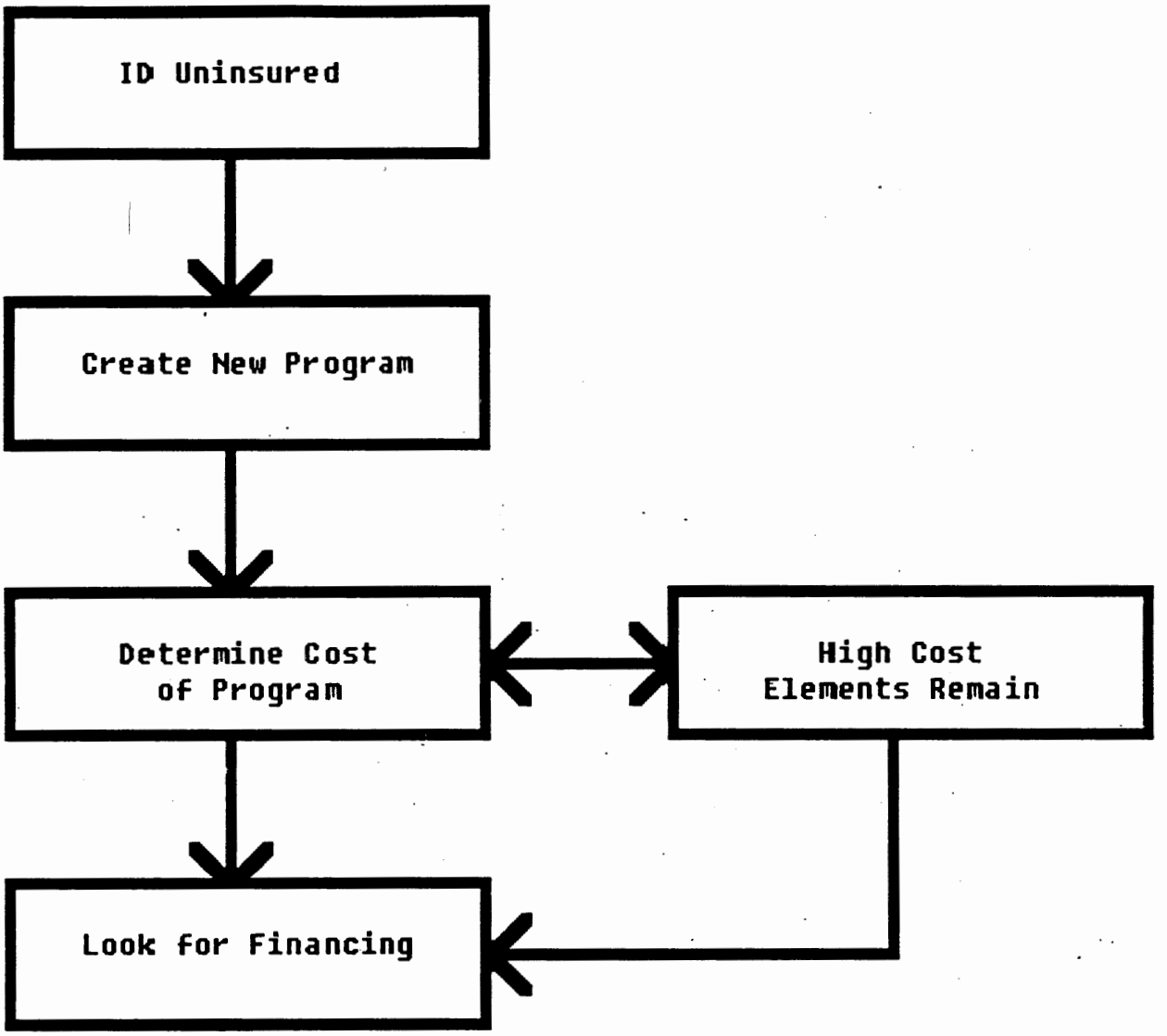

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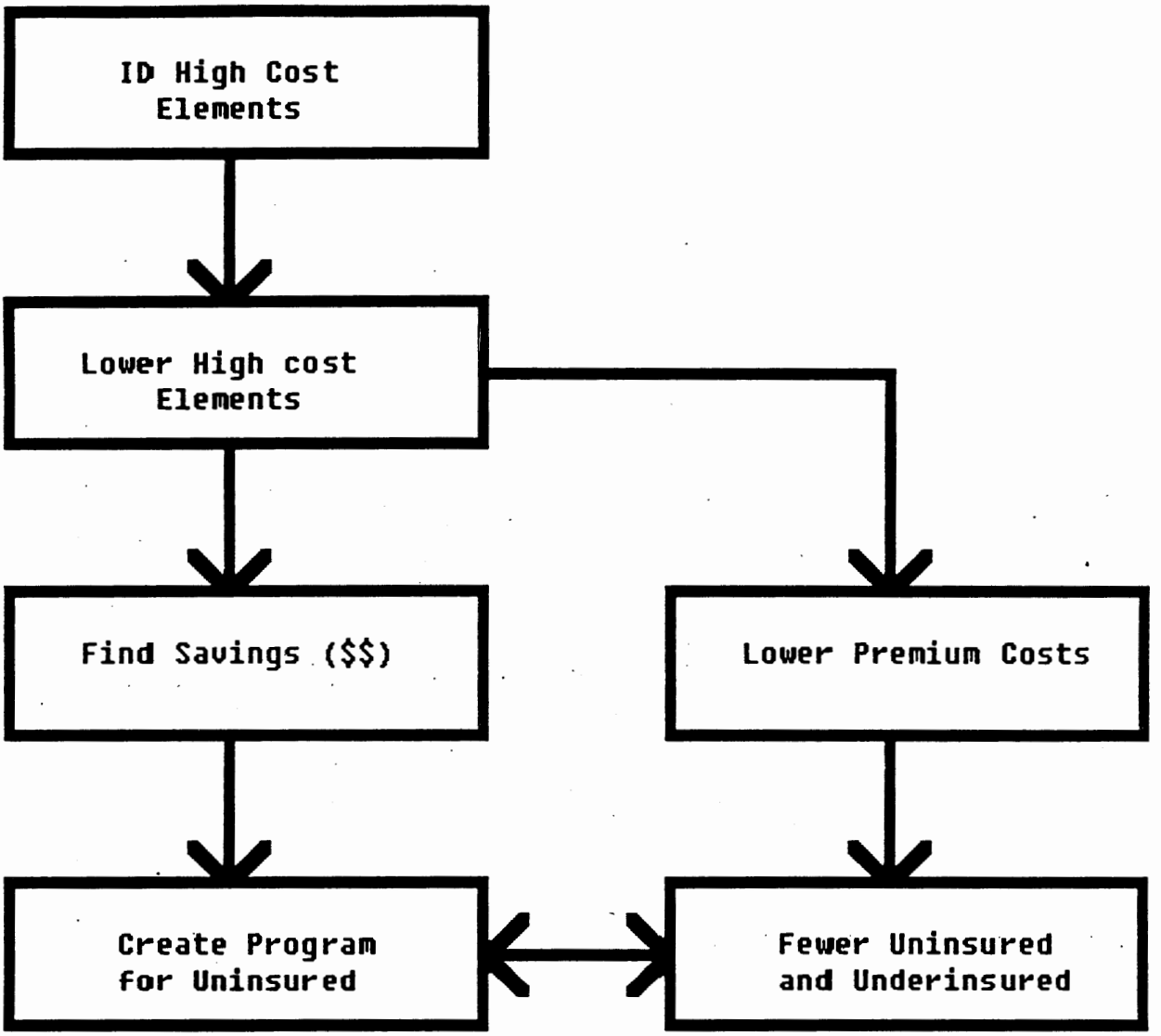
CHART #2

NEW APPROACH



In this proposal, U.S. Healthcare will present principles for a successful delivery system and discuss incremental changes that will deal with the priority aspects of cost. The proposal does not focus on major structural changes because within the existing framework, there is much that can be improved. It is on these areas that this proposal concentrates. Seemingly minor components are critically important, because when adjusted they can present major new financial revenues or savings.

As the largest health maintenance organization in New Jersey, serving over 380,000 persons, and as an HMO which serves a total of 1.1 million members in New Jersey and the neighboring states of Pennsylvania and New York, and in Delaware, Massachusetts and Connecticut, U.S. Healthcare (a/k/a HMO-New Jersey) can draw on a wealth of comparative data and over 16 years of successful experience to lend support to the conclusions reached here.

U.S. Healthcare, recognized by experts as a national leader in the HMO field, provides a high level of quality health care services to its members, with the demonstrated ability to contain costs. This is true in every state in which U.S. Healthcare operates, including New Jersey. However, because of the many barriers presented by the New Jersey's hospital reimbursement system, the cost savings are not as great as in neighboring states.

This proposal recommends the most fundamental goal for reform in New Jersey's health care delivery system would be to enroll all New Jersey residents in an HMO that conducts its functions at the highest levels of performance. And secondly, to provide incentives for those HMOs which meet strict state requirements to negotiate fair prices with selected providers, monitor utilization by members, and provide early detection and screening programs in such critical areas as breast and colorectal cancer detection and high-risk maternity.

To enhance the benefits that HMOs provide, the Commission is urged to make significant changes in several key areas. For example, HMOs should have the ability to negotiate per diems rather than to reimburse hospitals on a per-case basis, so that HMOs can reduce unnecessary hospital days and thereby, transfer the cost benefits to the public.

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Central to cost containment mechanisms is the ability to track HMO members' utilization. The Commission is urged to give HMOs the ability to do all pre-admission certification for hospital use as HMOs can:

- evaluate the clinical appropriateness of these procedures and

- help place patients in the most appropriate facility for the level of care required.

These two functions can eliminate a significant amount of waste[1].

Together, the payment of per diems and the pre-admission and concurrent review of hospital care has been proven effective in reducing hospital days for HMO populations by more than 40 percent over similar populations not in HMOs.

HMOs must be allowed to select the physicians and other providers necessary to offer all benefits covered by both public entitlement programs and private insurance. The HMOs have stringent provider certification criteria, and more importantly, have a process for periodic re-certification which is not currently systematically performed for any single provider group in the State. This recertification is based on quality, utilization and cost-effectiveness measures. The systems are well defined and have been proven effective over time.

If the optimal solution of enrollment in an HMO cannot be attained, the Commission should consider the introduction of the basic principles or elements of HMOs into the State's delivery system. Although this strategy is not as effective as using the principles in a single integrated and comprehensive program, it can have an impact if the principles are applied systematically and properly managed.

The following sections of this proposal contain a more detailed discussion of some of the elements of health maintenance organizations that appear to work and could be integrated into the reform of the health care delivery system in New Jersey.

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[1] In one report it is noted that a recent survey of benefits managers of companies employing 10,000 to 20,000 people indicates that pre-admission certification and concurrent review are the most effective methods of cost containment. Modern Healthcare, July 9, 1990; P. 39.

67X

Section IV, Specific Recommendations for Implementation, outlines key concerns about the hospital reimbursement and its system and methodology, physician services, and the benefit package to be offered to New Jersey consumers, and makes suggestions that the Commission can consider in its deliberations. Following that section is a brief discussion of the Medicaid system and the problem of the uninsured and uncompensated care.

This proposal is written to assist the Commission in their challenging and important task of finding answers for the New Jersey consumer of health care, and is proposed in the spirit of cooperation. U.S. Healthcare looks forward to sharing experiences, providing insight and expertise where possible and working with the Commission and the State Legislature in implementing a workable and effective health care reform plan for the consumers of New Jersey.

68X

IV. Principles for a Successful Delivery System

Introduction

The successful delivery system must incorporate mechanisms for containment of health care costs and achievement of high quality care into a program that will be available to all New Jersey residents.

As the delivery system is being modified to meet the changing needs of the population, and meet the need for high quality and cost containment, several key principles are emerging as important.

Three principles, which U.S. Healthcare sees as essential in reforming the health care system, are discussed here.

Principle No. 1: No major structural change.

U.S. Healthcare does not recommend major structural changes in the actual health care delivery system. Although there are those who are without health care insurance, it is not because of the basic system. Offering health care through employers is the most effective delivery system in the American society. The implication of this strategy is that New Jersey government must find ways to bolster the employer and not make it exceedingly difficult to offer health care benefits, and must establish an environment that is conducive to business growth and expansion.

Other systems are being studied. Many have looked at the Canadian system and advocated its application in the United States. But, our society is different. In the United States, citizens want the best health care, the most health care, and they want it on demand, without delay and without concern for cost.

In Canada, there is a lack of the availability of highly technological care that we have in the United States. Canadian citizens often wait for extended periods of time for elective procedures.

69X

Physicians are paid on a fee-for-service basis, according to governmentally determined fee schedules.[2] In Quebec, physicians' incomes are limited to a pre-determined maximum amount. [3]

None of these situations would transfer easily to a society that believes that sophisticated medical technology and procedures are inherently theirs, that waiting for even a short period of time is unacceptable, and where achieving a high level of income, without any limits imposed by government or society, is what everyone strives for .

Artificial - and often arbitrary - means of setting rates and fees has not worked to hold down health care costs. Promoting competition in the current system is what will work in the United States to meet the societal demands and at the same time control the costs.

Principle No. 2: Establish key components for quality and cost-containment

A delivery system that is successful in containing costs and achieving high levels of quality of care must include six key components. The result of these components, when fully integrated, will be the containment of health care costs and the ability to reach and maintain a high standard of quality health care. All of these can be fully integrated into the current, employer-based system of health care delivery and greatly improve it.

These components are:

(1) Economic incentives in a competitive atmosphere.

The provider community must be made more accountable for reasonable pricing of services. Relying on artificial constructs within the system, such as payment of hospitals based on DRGs, encourages spending to the reimbursable limit and does not allow the competition which is necessary to keep costs stable. Price sensitivity must be made a part of any payment system reform. Providers, like others in private industry or government, must learn to live within available and reasonable budget limits.

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[2] Canadian Health Care: The Implications of Public Health Insurance; HIAA Research Bulletin, June, 1990, Page 2.

[3] Id. at 33.

70X

(2) Careful selection and recertification of providers.

Providers must be held to the highest standards of quality to participate in the system so that consumers are assured of receiving the best care. Therefore, providers must meet stringent standards to be certified to participate and then monitored annually to continue to participate. "Performance Reports" on providers, that display outcomes of care and costs must be available for employers and consumers to be able to choose wisely.

(3) The assessment of clinical capabilities of these providers.

The State has granted "franchises" to hospitals and other licensed providers but not all perform at the same level. All licensed services should be recertified periodically to be sure they are performing against established standards. Those services that are not should be discontinued.

(4) Stringent monitoring of care at all stages.

Individuals requiring hospital care or ambulatory procedures should have readily available a review of the clinical appropriateness, the determination of the appropriateness of site and a concurrent review of inpatient care, and access to home care or other necessary follow-up care.

(5) Systemic tools that payers need to keep costs lower.

Payers must be involved in the health care process at all stages so that the interests of the consumers they represent can be protected. The ability to negotiate contracts with providers and health care facilities for competitive prices is one such tool.

(6) Education of the consumer and employer.

The consumer must be educated about the choices in the health care delivery system, about the value of healthy living styles and about the quality of the providers he or she relies on for care. The employer who offers health benefits to an employee must know about cost-effective options for care, be informed about the performance and effectiveness of providers and have the knowledge to assist and encourage his or her employees in living healthier.

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Principle No. 3: Establish HMOs as primary health care delivery method.

The health care delivery system that is best prepared to deal with the rising costs of hospital care and physician care and increasing concerns of quality and accountability, will incorporate the six components discussed previously into one comprehensive system. Implementing these components separately is not sufficient. To achieve their greatest impact on cost and quality, all the elements must be working in concert.

Health Maintenance Organizations provide the framework for these components to work, and U.S. Healthcare's recommendation is for the strong encouragement of HMOs for New Jersey residents.

The old health care delivery method of fee-for-service does not work for New Jersey today, any more than it works for the United States as a whole. The fee-for-service system operated best when there was little or no concern about cost or quality.

Times have changed. The New Jersey consumer deserves the highest quality care at the most cost-effective price. The functions of an HMO offer the possibility of achieving this.

Since the passage and implementation of the Federal HMO Act in 1973, HMOs have grown in greatly increasing numbers in both New Jersey and the United States. The number of individuals enrolled in HMOs in the United States has increased to 32.6 million members in 1989.[4] New Jersey's HMO enrollment is currently about one million persons.[5] In fact, experts predict that enrollment in such plans will grow even more significantly in the years ahead.

HMOs offer significant advantages in monitoring cost and quality: Utilization review, outcomes research and the development of practice guidelines, systems for the reduction of inappropriate and unnecessary care, pre-admission certification of inpatient hospital care, systematic review to have care provided in the most cost-effective setting and programs and education for preventive health care are basic to most HMOs.

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[4] Freudenheim, The Turnaround of the HMOs, New York Times, October 24, 1989.

[5] Doherty, HMOs Bounce Back, News Tribune, Feb. 4, 1990.

72X

HMOs deal directly with the cost elements in the health care system that are creating the problem of growing numbers and the uninsured and underinsured. And with the granting of broader authority in several key areas, HMOs offer the potential for creating a system in which the uninsured and Medicaid populations can successfully receive care.

In addition, one of the recent trends is the increasing number of employers who are requiring their employees to pay higher co-payments and deductibles as the cost of health care has increased. This has created numerous problems and has been at the root of problematic labor negotiations recently. HMOs offer a comprehensive benefit package with greater value, and reduce the need to increase employee cost.

Following is a discussion of how the six key components discussed in Principle No. 2 are successfully used in an HMO, and suggestions are made for strengthening each area in the New Jersey system.

(1) Competition

Managed Care is based on payment for services at negotiated, competitive rates. It forms a competitive environment in the health care system heretofore thought impossible to achieve. HMOs represent the consumer in purchasing hospital and other services. To work most effectively, HMOs need to be given the ability to negotiate fair prices and induce competition for volume into the marketplace with minimal restriction.

(2) Provider certification

The basis of an HMO is its network of providers. These providers are selected and certified to meet the highest standards of care for the consumer, and monitored continuously to be certain that such standards are maintained. Each provider is then required to meet those standards for periodic recertification. Provider accountability is an essential component in maintaining high quality for New Jersey residents, and HMOs should be permitted broader powers to assess provider credentials, including hospitals and others.

73X

(3) Assessment of clinical capabilities

Currently, HMOs are not permitted to perform cost-effective concurrent review of inpatient hospital utilization or retrospective medical reviews under New Jersey law. In prohibiting such review, New Jersey denies its citizens a higher level of quality review and puts this review function into the hands of the providers. New Jersey citizens enrolled in HMOs, unlike those in other states, are denied a basic service that has proven merit in reducing unnecessary and inappropriate care. The problem can be addressed by giving HMOs the power to review members' utilization at all stages of care.

(4) Continuous monitoring of care

When a consumer needs medical care, he or she deserves to know that the best care is given at all times, and that unnecessary or inappropriate procedures are not being performed. This requires the establishment of guidelines for appropriate care and continuous monitoring to apply these guidelines. It requires review and pre-certification of inpatient hospital care, concurrent review of treatment, and appropriate follow-up. And, it requires research into outcomes to assist in determining appropriate levels of care. The medical care that HMO members receive is under continuous review by Medical Directors and peer review committees of participating physicians, and these professionals work closely with Primary Care Physicians who provide care.

There is also a clear advantage in the use of HMOs for mental health and substance abuse treatment that meets the specific health needs of the patient instead of the cost needs of the providers.

(5) Systemic tools for keeping costs lower.

Managed care demands a fair price for the consumer. Managed care is able to offer a comprehensive benefit package at a cost-effective price by negotiating contracts with providers that pay for only those resources that are used. Because it can choose or not choose to do business with a given hospital it creates a price competitive environment. This gives the ability, not available with the DRG system, to maintain costs. When not constricted by the DRG system, HMOs can negotiate per diem contracts with hospitals that pay for only those days during which

74X

the patient is using hospital resources. By adding incentives to the reimbursement system, and removing barriers, HMOs will have the ability to fully institute their cost containment tools.

(6) Education

HMOs offer the opportunity to work closely with the member to educate about health care, to provide programs for healthy eating and living, and to alert the member when risk factors indicate a certain medical test or procedure is recommended.

This is a particularly important service for those populations that have not enjoyed access to the care of a primary care physician. For them, managed care is especially critical in fostering good health habits.

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CHART #3
KEY COMPONENTS OF DELIVERY SYSTEM

1. Economic Incentives in a Competitive Atmosphere

2. Careful Selection and Recertification of Providers

3. Assessment of Clinical Capabilities of these Providers

4. Stringent Monitoring of Care at All Stages

5. Systemic Tools that Payers Need to Keep Costs Lower

6. Education of the Consumer and Employer

V. Specific Recommendations for Implementation

This section details some of the particular problems that face the New Jersey employer and consumer today, and some specific suggestions for addressing these issues.

A. State Coordination

Create a High Level Council in State Government to Coordinate the Health Care Delivery System.

All of the state departments that are currently involved in the health care delivery system have their own particular areas of jurisdiction and expertise. The Health Department's substantive knowledge of health care, the Insurance Department's understanding of the rating and other insurance processes and the Department of Labor's experience with employers and employees all offer New Jersey consumers excellent service. However, there is a need for central coordination of these various departments to increase the system's efficiency, develop and coordinate the cost containment efforts and monitor for both cost containment and quality.

With a Director to run the operations of a council, its functions would include, but not be limited to:

a) coordination of the Certificate of Need Process throughout all departments,

b) development and implementation of health care demonstration projects,

c) review and monitoring of provider reimbursement rates,

d) assurance of integration of provider payment charges with insurance premiums,

e) development of quality standards for providers,

f) development of a comprehensive health care data base for consumer use and policy making purposes, and

g) recommendation of health care delivery policy changes to the Governor and legislature.

This newly created council would be the central point of focus for all of the health systems programs in operation in the state, and all New Jersey departments which effect health care policy would be represented.

77X

B. Health Maintenance Organizations

Adopt a revised HMO law to meet contemporary needs of employers and consumers.

As demonstrated in Section III of this Report, HMOs offer excellent potential for improving New Jersey's health care delivery system. Therefore, U.S. Healthcare urges the passage of a revised HMO law which is updated to meet the current and future needs of employers and consumers, and will assist HMOs in meeting the goals of cost-containment and high quality care.

A new HMO law would accomplish the following:

1. **Broaden the powers of HMOs.**
2. **Strengthen Quality Assurance Committee Proceedings.**
3. **Prohibit balance billing of HMO members by physicians and hospitals.**
4. **Prohibit billing of HMO members for any medical services covered by their HMO policy.**[6]
5. **Provide incentives to encourage hospitals to negotiate per diem contracts with HMOs.**
6. **Create tax incentives for employers to offer HMOs and to consumers who become members of HMOs.**
7. **Exempt HMOs from the requirement of offering mandated benefits beyond a minimum package.**
8. **Give HMOs the ability to conduct concurrent review of Members' hospital care.**
9. **Give HMOs representation on all State commissions and boards that advise on health care delivery.**

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[6] A 1989 Maryland State law which states, in part: "Individual enrollees and subscribers of health maintenance organizations shall not be liable to any health care provider for any covered services provided to the enrollee or subscriber," was held by a Maryland Circuit Court Judge to protect HMO members from hospital billings whether the providers had a contract with the HMO or "had merely treated the patient as a independent provider". Judge Limits Hospitals on Billing HMO members, The Sun, April 28, 1990.

78X

Specifically, U.S. Healthcare recommends the adoption of those provisions now contained in New Jersey Senate Bill #393, introduced by Senator Richard Van Wagner, and entitled the "Health Maintenance Organizations Act of 1989," which further these goals.

This legislation is a positive beginning to revising the HMO law, and contains numerous provisions which will strengthen the powers that HMOs currently have and which have assisted in the growth of HMOs in New Jersey. If passed, it will add new provisions that will allow HMOs the flexibility to adapt to the changing needs of employers and consumers in New Jersey.

The Commission is urged to advocate legislation that would not unduly burden HMOs, either on a competitive or administrative basis. Several proposals now before the Assembly and Senate would create such a situation, and hinder the ability of HMOs to successfully address the State's health care problems.[7]

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[7] New Jersey Senate Bill #393; P. 18; Lines 12-22; Section 26. One of these is in regards to transplantation procedures, and requires an HMO to provide for such, regardless of their possible status as "experimental or investigational". This is too broadly defined, and, although some discretion is vested with the Commissioner of Health, could result in adverse selection and a competitive disadvantage with other payers.

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C. Hospitals: Costs and The Rate Setting Process.

Primary Recommendation:

Repeal DRGs as basis for hospital payment

and create an unregulated competitive system.

The present system of basing payment for hospital costs on DRGs has not met the expectations surrounding its passage into law and implementation in the 1970's. Hospital costs in New Jersey have risen dramatically since then, and for U.S. Healthcare, far exceed those in Southeastern Pennsylvania and are higher than those in New York. With over 380,000 members in New Jersey, U.S. Healthcare's experience is substantial and gives an accurate indication of a trend experienced by other payers. The most dramatic acceleration of hospital payment increases has taken place in the second half of the 1980's.

Since 1986, New Jersey hospital payments for U.S. Healthcare members have increased at a far more significant rate than for either of the neighboring states of Pennsylvania or New York. From 1986 through 1989, per member per month costs in Southern New Jersey and Northern New Jersey increased 91.6% and 135.7%, respectively. In 1989 alone, hospital cost increases on a per member per month basis were 38% over 1988. For U.S. Healthcare members, southern New Jersey's per case payments are currently 40% higher than for members in southeastern Pennsylvania. In northern New Jersey, per case payments are currently about 9% higher than New York City's payments.

In one year, from January 1988 to January 1989, HMO-NJ's hospital reimbursement rates increased by 29%, based on the increased in the State promulgated hospital reimbursement mark-up factor.

These costs are reflected in the medical experience portion of U.S. Healthcare's premium rate filings, and must be reflected in the premium cost for employers. These rising costs are directly tied to the growing number of employers who cannot afford to offer health benefits coverage to their employees.

80X

This increasing spiral must end if New Jersey is to contain costs in health care. The Commission can begin by removing from the hospital reimbursement system the regulations that have fostered the problems.

The System is complex and confusing.

First, the system is so complex that the majority of the passages in the law which explain the process are understood by only a few. An example of the language found in the implementing regulations illustrates this point.

> "1. The reasonable Direct Cost Per Case (DRG) of the Preliminary Cost Base for those hospitals receiving rates in accordance with this subchapter determined for all hospitals, for every DRG with greater than five merged patients and shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:
>
> degree of confidence x labor market standard, calculated after teaching costs have been removed from hospitals' Preliminary Cost Bases, x the amount and type of Graduate Medical Education
>
> plus
>
> (1-degree of confidence) x hospital current non-physician direct cost per case
>
> plus
>
> hospital current physician patient service cost per case
>
> i. where the degree of confidence of a DRG is one (1) minus the DRG's coefficient of variation;
>
> ii. And where the coefficient of variation of a DRG is the standard deviation divided by the mean, or incentive standard cost;
>
> iii. And where the standard deviation of a DRG is calculated across all patients in the DRG in the given teaching category;
>
> iv. And if the Coefficient of Variation, as calculated above, is greater than 1, the degree of confidence shall equal zero. (Reasonable non-physician direct cost per case equals hospital's costs per case.)"[8]

Whenever a system presents this much complexity and confusion, it is inevitable that there are going to be delays in its proper implementation. In fact, the New Jersey Hospital Rate Setting Commission is years behind in final rate reconciliations, with the result that hospitals' rates for years as early as 1987 are being finalized, and reconciliations from that year are still being considered.

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[8] N.J.A.C. 8:31B-3.23 (a)(1)

81X

DRG payments are not for actual cost of services used.

The DRG system is an artificial and arbitrary means of setting rates. DRG's were initially developed as a data collection method for utilization review purposes and not for reimbursement. Payments under the DRG system are not directly related to the cost for services used, but are indirect estimates for a broad category of medical procedure. As a result, consumers are paying more in many cases than they should. Recent newspaper accounts of hospital bills which show the payment required for the treatment given to be far more under the DRG cost than the actual cost have increased the public's skepticism about this system.[9]

DRG system does not give hospitals incentives to contract outside of it.

Finally, hospitals which are interested in working with HMOs to provide competitive rates are constricted by the DRG system. Although HMOs and hospitals are not precluded from negotiating for competitive pricing, the system does not encourage it.[10]

DRG system does not allow payer oversight.

The DRG system is a closed system, whose per case payments do not allow for "oversight" by payers. As an example, HMOs cannot utilize concurrent review of members' care to save costs.

DRGs have not reduced lengths of stay.

DRGs were supposed to have reduced lengths of stay in hospitals, but there is no clear evidence to support this. Instead, the system has disincentives to reduce the length of stay: Why encourage shorter stays in a hospital if the payment will remain the same with extra days?

The State of Connecticut, in response to the public's desire to make changes in their system, recently repealed the law that implemented DRGs as the basis for payment. U.S. Healthcare's primary recommendation is for New Jersey to join in that move and institute progressive payment reform by repealing its DRG based system.

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[9] Whitlow, Hospital Bill Mark-ups Spur Scrutiny of Rates; Sunday Star-Ledger; April 1, 1990.

[10] See, N.J.A.C. 8:31B-3.39.

82X

Alternative Recommendation:

If DRG system is kept, or if system remains regulated, then make substantial changes to improve payment methodology.

U.S. Healthcare recognizes that, although the DRG system has presented health care cost increases for the State, some believe that abandoning it quickly would present some problems. If the Commission makes the determination that the DRG system should remain, the recommendation is to enact real reforms that would assist in having this system attempt to fulfill the expectations that led to its creation.

Implement methodology for hospital reimbursement through detailed statute rather than regulation.

N.J.S.A.26:2H-4.1 establishes the New Jersey Hospital Rate Setting Commission, and empowers it to "approve or adjust" a hospital's preliminary cost base and "approve an appropriate schedule of rates."[11] The Commission is also responsible for the certification of a hospital's revenue base. Neither this section nor any other in this statute provides a more detailed explanation of what shall constitute the preliminary cost base, the schedule of rates or the certified revenue base. All of these, and in fact all other aspects of the rate setting methodology, are done by regulations proposed by the Commissioner of Health.[12]

As a result, there is no opportunity for the legislature to approve, disapprove or change the system. Although public comment is permitted for the implementation or change of regulations, this process lacks the degree of accountability to constituents that would be attained if statutory change were involved.

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[11] A 1989 New Jersey Superior Court decision interpreted the law to include the authority to pass upon the final reconciliation methodology used by the Department of Health. Matter of 1982 Final Reconciliation Adjustment for Jersey Shore Medical Center, 209 N.J. Super. 79 (App. Div. 1986).

[12] The current regulations span more than 200 pages in the New Jersey Administrative Code.

83X

U.S. Healthcare recommends that more substantive requirements for the rate setting system be implemented by statue, rather than regulation, to allow employers and consumers a greater awareness and more active involvement in the process.

If DRGs are kept as the basis for hospital payment, make the system truly prospective with rates set and effective for a fixed time period.

It is clear that what was supposed to be a prospective system of rate setting is nothing near that. Instead of fostering long term stability in rates, the system creates continuous uncertainty.

The Rate Setting and Reconciliation Process is too long.

The process for setting hospital rates and determining reimbursement, from the time of initial rate setting by the Department of Health and through until final reconciliations are complete, takes far too long. The regulatory process for initial rate setting, review of appeals and Hospital Rate Setting Commission determinations specifies a time period of 14 total months.[13] In reality, hospital appeals are not limited. Each appeal by a hospital adds more time, and the actual length of time far exceeds the 14 month period.

Hospital mark-up factors are not stable.

Hospital mark-up factors change too frequently. In fact, payers often are faced with mark-up factors that change monthly. Changes can be made whenever a hospital returns to the Rate Setting Commission and receives a rate change, with few limits on how often this can occur. Because of these constant changes and fluctuations in the mark-up factor, payers are faced with instability and uncertainty, and the result is higher costs.

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[13] N.J.A.C. 8:31B-3.1 et seq.

84X

Payers, including HMOs, file premium rates only one time per year, and these rates are set for that time. Employers who pay these premiums would not be able to budget properly if they were faced with monthly increases in premium rates, so payers do not make those adjustments. However, payers incur the losses associated with unscheduled hospital rate increases which creates much variance in medical costs.

The Commission can address this problem by proposing a statutory time period when hospital rates are set and effective and a limit on the number of hospital appeals.

Base hospital reimbursement on attainment of efficiency, cost and quality standards.

The present system of hospital rate setting does not require hospitals to adequately justify costs, demonstrate efficiencies, economies of scale or efforts to implement such measures as a condition for reimbursement.[14] To the contrary, hospitals that demonstrate such cost-containment measures on their own in the form of price competitive contracting with HMOs, are viewed skeptically and penalized.[15] When a hospital requests higher reimbursement from the Hospital Rate Setting Commission, there is no standardized method of determining whether or not the hospital has implemented cost-containment or efficiency measures. To be awarded higher reimbursement, the hospital need only demonstrate losses, expenditures and other outlays. A hospital that uses its ability to reduce cost and price at a rate to attract higher volume should not be penalized but rewarded for the effort.

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[14] Throughout the Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) and the regulations accompanying it, there is mention of quality, efficiency and cost as concerns. However, there is no provision that requires the attainment of these as a condition for reimbursement.

[15] U.S. Healthcare has been informed on many occasions by hospital CEOs and CFOs that they are financially better off not controlling cost and walking away from potential volume because their State reimbursement would be adversely effected. This may be technically untrue, but the perception is that the State will always come to their rescue even though an increase in volume would actually reduce unit costs to all payers.

85X

Allow greater public and payer access into, and information on, hospital reimbursement system.

Currently, employers, consumers and payers are permitted little access into the Department of Health and hospital rate setting and review process, and to the materials that are used by the Hospital Rate Setting Commission in making their decisions.

For example, until recently, attendees to the meetings of the Hospital Rate Setting Commission were not given the ability to review materials until several minutes prior to the start of the meeting. Although public comment is requested at the meetings, it is difficult to do so on unreviewed financial information. This is unfortunate, as the decisions that are made at these meetings are a major determinant of overall health care costs. Hospital costs are, by far, the largest portion of any payer's budget for health care services, constituting 25% to 40% of total medical expenses. The Hospital Rate Setting Commission has begun to move in the direction of improving access by allowing the public to see these materials in advance of the day of the meeting, but greater access should be granted.

The Commission can address this problem by proposing that all essential information used in setting rates be available to the public. Included in this proposal would be the requirement that hospitals publicly disclose all interests in and financial dealings with for-profit ventures and non-health care holding corporations, and the amount of payments to physicians or other consultants and contractors. In this way, the consumers and employers will have all of the information essential to accurate decision-making.

86X

Make all hospital costs volume variable and require hospitals to maintain specified volume of services.

Like hospitals throughout the United States, hospitals in New Jersey are not operating at 100% capacity. In New Jersey, however, the DRG system is structured to meet the State's commitment to keeping all hospitals--regardless of capacity--financially solvent.[16] This adds much to the cost of hospital care, as it subsidizes unused facilities and inefficient operations.

In the current DRG system, only a few costs are volume variable.[17] All others are fixed and not affected by volume, even though the addition of new patient volume can reduce the unit costs of operation. As a result, there is little incentive for hospitals to contract competitively and provide lower costs.

Basing costs on volume requires hospitals to compete for patients, and allows payers to negotiate with the hospital to provide volume for a reasonable cost. The consumer and the employer benefit with lower health care costs when competition is made a factor. To improve this situation, the Commission is urged to:

a) Make all hospital costs volume variable.

b) Impose penalties on hospitals which do not maintain volume, given a standard length of stay.

c) Decertify hospital services which do not maintain volume.

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[16] N.J.S.A. 26:2H-1.

[17] With some exception, inpatient indirect costs are volume variable; and subject to a unit cost; same day surgery indirect costs are volume variable. Outpatient indirect costs remain fixed. N.J.A.C. 8:31B-3.24(c)(7).

87X

Integrate payment to hospital-based doctors into total hospital payment in recognition of the effective monopoly granted them and create incentives for cost savings.

Create incentives for HMOs to negotiate contracts with hospitals which include hospital-based physicians in per diem rate.

In New Jersey, when a payer contracts with a hospital, the hospital-based doctors are not included in the fee. Instead, the payer must contract individually with these physicians, including radiologists and anesthesiologists.

This has created a monopoly situation, which has greatly increased the cost for these services. Hospital-based doctors, who use hospital personnel and equipment, can charge whatever they want because they are non-competitive, and hospitals either cannot or choose not to control them because their services are essential. Payers cannot purchase hospital services as a package and so, there are no incentives for these services to be priced competitively or economically. In many instances, these physicians refuse to consider a contract and insist on payment of 100% of charges. The payer has no alternative because they cannot freely bring outside physicians into a hospital which has an exclusive physician contract.

If any cost containment is to result, and if any savings are to be realized, these physicians must be included in the hospital payment. As long as there is a monopoly, there will be no reason for costs to decrease.

If HMOs are given more incentives and encouragement to negotiate per diem rates with hospitals, the state should require that these physicians' services be made part of that per diem rate.

88X

Revise CON Process for uniform application, to add monitoring oversight and to ensure that only cost-effective and high quality facilities,services or equipment are permitted into the delivery system.

The Certificate of Need process is an essential component of the health care delivery system and a critical aspect in cost control, and the Commission should focus on improving it.

The current certificate of need requirements have not been applied uniformly - physicians are not routinely subject to the CON process - and have allowed the unnecessary duplication of many health facilities and medical services.

This has permitted the uncontrolled purchase of high cost equipment by many facilities in close proximity, with the result that prices are raised to justify the purchase. If many facilities have the equipment, then the use per unit will be lower, and per unit use charges will have to be higher.

Once approved, the debt incurred by the purchase of facilities and equipment becomes the fiscal responsibility of the State and the rate setting process. This guarantee of reimbursement encourages duplication, inefficiency and increased costs. The debt incurred to purchase all other facilities and medical equipment should not be subject to certificate of need and should not receive compensation from the state.

Only facilities or services that are essential to the consumers of New Jersey, and are of such magnitude that a public discussion about the cost and placement of these services is necessary, should be subject to the certificate of need process.

89X

Revise CON process to require as condition of receiving and maintaining the privilege to have equipment or service the demonstrated adherence to high quality standards by developing Performance Reports for Providers.

By granting a request in the CON process, the State is extending a privilege to a hospital to offer a service. Along with that privilege should come the responsibility for consistently meeting stringent standards for quality and cost effectiveness. These standards, set by the Commissioner of Health, should be a primary consideration in granting an initial request, and then reconsidered at continuous intervals while the service was offered. It is recommended that the Commission on Health Care Costs propose the annual review and recertification of facilities to determine if these standards for high quality and cost effectiveness have been maintained. If these standards are not met, the privilege would be revoked and the associated costs disallowed in reimbursement.

Also, in the system as it is constructed today, there is little opportunity for the public monitoring of the quality of care that physicians or hospitals provide. The system requires no reporting to payers or consumers or employers of the quality of care being delivered.

The result is that consumers and employers are unaware of the quality of the health care for which they are paying, and may be choosing care that is of poor quality . Many consumers are making choices based on incomplete or inaccurate information and the result may be a harmful one. Many HMOs have instituted comprehensive programs to monitor the quality of their Members' health care, but the State must also play an active role.

As part of this certification and review process, it is recommended that the information on provider performance that is reviewed be issued to the public. By requiring publicly available "Performance Reports" on providers, both consumers and employers would have access to important health care information.

 90X

Prohibit hospitals from shifting Medicare payment "shortfalls" to consumers and employers through private payers.

At the end of 1988, Medicare made a determination that has had a significant impact on New Jersey hospital costs: No longer would Medicare pay the state-approved DRG rate. Instead, it would pay its own lower rate. But New Jersey hospitals can pass that differential to private payers; they are not required to meet this change by "living within their means" as are hospitals in other states.

The result has been drastic increases in hospital costs for private payers as the Medicare shortfalls have been shifted, with State law requiring such payments. "In 1990, $1 billion in hospital bills will have to be assumed by insurance companies, HMOs and individuals because of Medicare's decision to shift costs and the surcharge built into the hospital rates to cover uncompensated care." [18] The statewide 1989 Medicare cost shift for New Jersey was **$116 million**. This resulted in hospital mark-ups of 1.5 (7 hospitals) to 4.0 (13 hospitals). The remaining 63 hospitals were somewhere within those two numbers. [19] It has been estimated that the 1990 Medicare cost shift will add an additional $550 million to New Jersey Hospital bills this year. [20]

This cost shift to private payers amounts to a "tax" that is levied on New Jersey's businesses and individuals without their consent or knowledge. Neither the quality of care nor the efficiency of operations is benefited by this action; it only fosters unchecked spending and failure of public accountability, and will ultimately damage the State and harm the economy.

In New York, the post-1988 waiver removal decision was treated entirely differently, and it is the recommendation that New Jersey follow in the same manner. New York hospitals are not permitted to shift the costs of Medicare "shortfalls."

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18 Jaffe, Crisis Looming in Health Care Insurance, Star Ledger, February 11, 1990.

19 New Jersey Hospital Rate Setting Commission Memorandum, "RE: 1989 Final Medicare Cost Shift", October 27, 1989.

20 Friedland, State System of Hospital Rates Drawing Fire, New York Times, July 1, 1990.

91X

The New York Public Health Law, Section 2807-C(1)(d), provides that in determining the DRG rates of payment of all New York State payers, "inpatient operating costs related to services provide to beneficiaries of Title XVIII of the Federal Social Security Act" are to be excluded. This statutory section was tested by the New York State Commissioner of Health, but was upheld by the Supreme Court of the State of New York as prohibiting the shifting of Medicare costs by hospitals to private payers.[21]

In addition, when the Department of Health of the State of New York proposed legislation that would change this statutory provision and nullify the court decision, the effort was not accepted in the legislature.[22]

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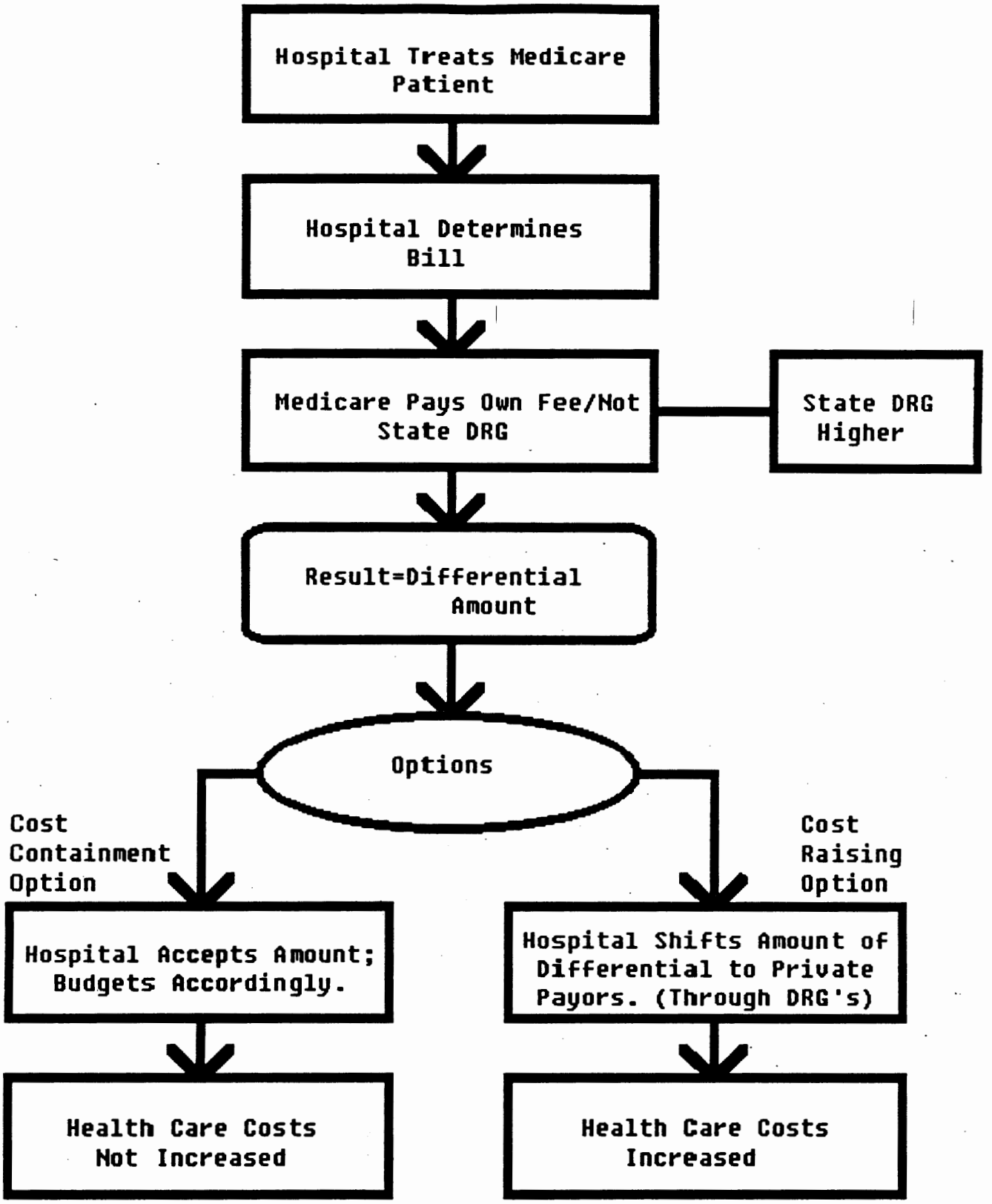
[21] New York State Conference of Blue Cross and Blue Shield Plans v. David M. Axelrod, Index No. 3632-89 (Sup. Ct., Albany County, July 14, 1989)

[22] State of New York, Department of Health Memorandum, 1990 Legislative Proposal #43R-90.

92X

MEDICARE COST SHIFT



GOAL: REFORM SYSTEM TO PROHIBIT COST SHIFTING SO THAT EMPLOYERS DO NOT BEAR BURDEN OF UNLIMITED HOSPITAL SPENDING.

93X

D. Physicians Services

Prohibit physicians from billing individuals in excess of a fee that they have agreed to accept from a third party payer or Medicare.

In some situations, physicians will agree to accept a pre-determined amount of payment from a third party payer, and then following the rendering of the service, will bill the consumer for a remaining amount. This can also occur with Medicare patients, as the physician will bill the Medicare patient for the balance of a bill for which Medicare paid only a portion. This practice is called "balance billing."

HMOs offer their members the advantage of no claim forms and no bills to pay. When a non-participating physician threatens to send a bill to a member for the balance of a bill, the HMO must pay in order to fulfill the promise to the consumer. Unfortunately, some physicians take advantage of this situation.

Although the vast majority of physicians do not practice in this manner, there are some physicians who continue to operate this way. This is an abuse that is perpetrated on the consumer and the employer who provides health benefits. If physicians agree to render a service for an amount of money that is negotiated directly or is accepted by performance, that should be the final amount they receive. Contracts between providers and payers for specified amounts are a key element in containing costs, but balance billing nullifies those cost savings.

U.S. Healthcare recommends that the Commission take a strong stand against such abuse, and amend the HMO law (and other insurers' laws) to prohibit such action by physicians. These changes should address the problem for both Medicare and non-Medicare patients, to avoid shifting costs in either direction. The Commission can signal its displeasure with such action by imposing penalties on physicians who exhibit a pattern of balance billing.

94X

Prohibit physicians from unbundling or "exploding" bills to falsely increase reimbursement.

One way in which some physicians increase their reimbursement from third party payers is by manipulation of CPT (Current Procedural Terminology) Codes in their billing. CPT codes were developed by the American Medical Association to provide uniform language for reporting medical services and procedures, but have provided the framework for some physicians to intentionally bill for greater payment than the procedure performed requires. It must be emphasized that it is a small minority of physicians who use these codes for anything other than proper billing, but if the experience of U.S. Healthcare is any indication, this small group of persons is ultimately costing the consumer, the employer and governments a substantial sum of money.[23]

The problem occurs when billing is done using the codes for the component parts of a procedure rather than the code designated for the procedure as a whole. For example, several codes are for various individual procedures for a hysterectomy, and one code combines all of those parts into one. Some physicians will submit a bill which asks for payment for each of the individual parts. The total amount to be paid when each of these components is added is greater than if the physician billed with the code for the entire procedure.

The result is higher costs to the payer, and higher costs ultimately to the employer who purchases health benefit coverage. GMIS, a firm that has developed software to detect unbundling, estimates that payers lose between $1 billion and $2 billion annually to "code gaming". "The incidence is widespread and touches on all sub-specialties of surgery and internal medicine, as well as radiological and laboratory services," the company states in a recent analysis of claim overpayments. "Recent studies conducted on surgical claims...reveal that on average one-fourth of all multiple procedure claims contain a coding manipulation or overpayment problem." [24]

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[23] U.S. Healthcare has instituted a program to detect unbundled bills, and recovered $1.9 million in 18,000 surgery claims. This program is expected to save $10 million in this year.

[24] Kirshner, Dueling Software: Views differ over what constitutes accurate Billing, Managed Health Care; March 12, 1990

95X

U.S. Healthcare recommends that the Commission take the following action:

(1) Develop a definition of a pattern of abuse of CPT billing, and classify as fraud, with imposition of civil monetary penalties.

(2) Amend the HMO law to allow an HMO to refuse to pay a physician who demonstrates a pattern of abuse of CPT code billing, with notification requirements to New Jersey Departments of Health and Insurance and with administrative appeal provisions.

E. Consumer Benefit Package

Primary: End all state requirements for mandated benefits beyond a minimum benefit level; In the alternative, revise process for implementing new mandated benefits.

Whenever a new treatment or benefit must be covered by an insurer, there is an additional cost to employers and consumers. Since most insurers already provide the "basics" - inpatient hospital, physician services and other outpatient services - the additional benefits required are generally those which affect a smaller, more specific portion of the population and which carry high costs.

Mandating benefits has a multiplier effect: first, the added cost for more expensive procedures; second, higher health benefit premiums to cover that cost, and third, fewer employers able to purchase health care coverage.

In Oregon, there is a proposal under consideration which would allow rationing of health-care treatment by the State for Medicaid patients. Payment for the more expensive, less used procedures would be eliminated in favor of preventive care and treatment which would benefit a greater portion of the population.

The Commission is urged to seriously study the negative impact of the increasing numbers of mandated benefits before rationing becomes necessary. The Commission should:

(1) Establish a minimum benefit package that must be offered by those insurers who offer benefits, but allow insurers the option to offer a broader or more comprehensive package.

97X

And in the alternative,

(1) Require any new mandated benefit proposed in the legislature to undergo a cost/benefit analysis, with payer and public comment solicited.

(2) Allow any newly established mandated benefit to be implemented only one time per year, to decrease instability in medical costs for insurers and allow insurers to adjust rates accordingly; or for any procedures determined to be a mandated benefit for an insurer, allow insurers immediate rate adjustments.

(3) Assemble a panel of experts to make the determination of what should be an experimental or investigational procedure and give Commissioner of Health the authority to develop guidelines and write regulations for implementation.

98X

VI. Medicaid

Revise and Expand Medicaid Program

The Medicaid program in New Jersey has not been as strong as in other states, and U.S. Healthcare encourages the discussion to revise and expand that program. At the federal level, important changes are being discussed which would provide incentives for enrolling Medicaid recipients in managed care programs, and similar proposals could assist the state in providing for this population.

In this matter, U.S. Healthcare recommends the following as a starting point for discussion on this important issue:

(1) Expand Medicaid eligibility.

(2) Create open, competitive market system where Medicaid recipients are given vouchers to use for selection of private insurers that meet state determined levels of quality.

(3) Establish quality and cost standards for providers for certification and annual recertification as condition of participation in Medicaid Program.

(4) Develop incentives for private HMOs to enroll Medicaid recipients.

99X

VII. Uncompensated Care: The Uninsured

Revise system for financing care for the Uninsured.

In the first section of this proposal was the recommendation for changing the approach to reform of the health care system to addressing cost concerns first, to lower the number of uninsured, and then creating programs for financing that care. In keeping with that, this section follows the discussion of specific methods of cost reform and completes the proposal.

As the cost of medical care rises beyond the affordability of employers, and as employment opportunities decrease, the numbers of uninsured are rapidly increasing. The system as structured, with a surcharge for uncompensated care on all hospital bills, means that a shrinking number of employed individuals and their employers are bearing the cost burden for a larger pool.

The surcharge system is an "after-the-fact" payment, so that payment is for health care already rendered. This presents several problems: Since care is at hospitals, the cost is higher; there is no quality monitoring of the care that is received; and care is generally emergency care because it is not sought until that stage. The system is not designed to provide preventive or ongoing care. Early intervention into the health care cycle is critical. Less costly care occurs as preventive care, in the form of wellness programs and treatment in non-hospital settings. Emergency room care must be used for real emergency situations if costs are to be contained.

U.S. Healthcare urges the Commission to analyze various possibilities for the financing of care for the uninsured, with the consideration that all New Jersey hospitals should continue to be required to absorb a portion of that care as a requirement for maintaining their non-profit status. In many states in the United States, legislatures and courts are beginning to look again at the commitment that hospitals are supposed to be making as a condition of their tax-exempt status,

100X

and revoking that status where hospitals are not providing the appropriate levels of care for the uninsured.[25]

All businesses incur bad debt when goods or services are provided, and payment is not rendered. In New Jersey, however, the law makes hospitals whole with its policy of financial stability. To continue to allow hospitals to be reimbursed for all bad debts will only escalate costs further. It is a circle that must be broken: High hospital costs create higher insurance costs, which create more uninsured, who receive services from hospitals, which are then reimbursed by the State, which raises insurers costs and creates more uninsured.

Several suggestions for discussion are made here for the Commission to consider in addressing the problems of financing of the uninsured:

1. Require hospitals to absorb a portion of care for uninsured as condition of maintaining their tax-exempt status.

2. Require hospitals to establish community outreach programs to decrease high cost emergency room use by uninsured persons.

3. Finance extraordinary hospital bad debt for treating the uninsured with pool of funds from a hospital surcharge and tax on not-for-profit hospital real property, which would be dedicated to funding uninsured care. (Designated hospitals or others with high impact from uninsured care would receive credits.)

4. For-profit insurers that pay State income taxes should receive a credit for those taxes and pay proportionately less for the Uncompensated Care Fund.

5. Designate hospitals in multi-hospital cities as the facilities for indigent care, to allow for monitoring of quality and containment of costs.

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[25] See eg, Gapen, Showdown on Charity Care Menaces Hospital Tax Status; Healthweek, July 16, 1990 for a discussion of the dispute between Methodist Hospital in Houston, Texas and the state's Attorney General.

101X

VIII. Conclusion

The Commission is developing its proposals for reform of the New Jersey health care delivery system at a critical time. Although many persons cite the problems in the health care system today as reaching "crisis" levels, there are as many who feel that the situation is not at its worst.

New Jersey can take the lead in developing a system that will meet the quality concerns of consumers, provide access to health care to all residents and establish solid mechanisms that will increase competition and stabilize costs.

The recommendations offered in the proposal are derived from the actual experience of providing care to over 380,000 persons. U.S. Healthcare has been growing in New Jersey, and looks forward to serving the state's residents with high quality, cost effective health care. It is hoped that the suggestions here will be useful to the Commission in implementing a system that will encourage such care for New Jersey residents.

102X

RECOMMENDATIONS FOR CONSIDERATION

IN STATE HEALTH REFORM

1) Medical practice guidelines.

2) Remove incompetent Physicians.

3) Consult Radiologists:
   Prior to sophisticated tests being ordered by non - specialists.

4) Preventive Health Measures:
   Should focus on early school education and involve local physicians.

5) Personal Responsibility for Well being and Safety:
   Higher premiums for people with habits/life styles which are health risks - smokers, drug users, speeders, drunken drivers, etc.

6) Mean - Test for Medicare assignment.

7) State Health Planning Board should include Physicians (medical and osteopath), and hospitals.

State of New Jersey
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF EXAMINERS OF OPHTHALMIC DISPENSERS AND OPHTHALMIC TECHNICIANS
1100 RAYMOND BOULEVARD ROOM 501
NEWARK NEW JERSEY 07102
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Robert J. Del Tufo
ATTORNEY GENERAL

Patricia A. Royer
DIRECTOR

November 14, 1990

Senate Institutions, Health and Welfare Committee

Mr. Chairman and Committee Members:

I am Robert C. Troast, active Chairman of the State Board of Ophthalmic Dispensers and Technicians.

As a state board which licenses and regulates opticians, we are totally in favor of Section CR17 of the Governor's Commission on Health Care Costs.

Reasons: Physicians have no education or training in the practice of ophthalmic dispensing, which is the skills and techniques of producing and reproducing ophthalmic lenses, spectacles, eyeglasses or appurtenances thereto to the intended wearers thereof. This is opticianry.

The Physician is duly licensed to practice their profession which is to examine, treat and operate on the eye.

I have heard of a study done by the California Consumer Department on doctor dispensing and the study reported a one third over prescribed, unneeded eyewear,and which eliminated the competition in the market place.

At present, the Board of Ophthalmic Dispensers and Technicians in conjunction with the Medical Board are investigating doctors who just delegate dispensing of eyewear by unlicensed and untrained personnel which violates the optician law and the public's right to proper professional care.

As a board we investigate consumer complaints. How are these complaints best handled in the public's interest?

1. After investigation and it is found to be improper examination or treatment, the complaint is referred to the Medical Board.
2. After investigation and it is found to be improperly fabricated or fitted eyewear, the complaint is handled by the Board of Ophthalmic Dispensers and Technicians.
3. If the complaint involves improperly fabricated or fitted eyewear which was dispensed by a phyciain, the complaint is investigated by the Medical Board who has no knowledge in fabrication and fit of eyewear.

104X

This puts the Medical Board in a very anomalous position to investigate in which they have no training or knowledge. Where is the consumer protection in such a situation?

Therefore, the Board of Ophthalmic Dispensers and Technicians knows the public will be better served if CR17 becomes law by separating the Prescriber from the Dispenser.

Then the prescriber will be controlled by the Medical Board and the dispenser controlled by the Board of Ophthalmic Dispensers and Technicians.

Guild of Prescription Opticians of New Jersey

November 14, 1990

Mr. Chairman and Comittee Members:

The Guild of Prescription Opticians of New Jersey Code of Ethics and Bylaws forbid a Guild Optician member to affiliate with an eye doctor in any business relationship, i.e. total separation of the examining and prescribing individual from the supplying, dispensing individual.

Accordingly, we, the New Jersey Guild, wholeheartedly support CR17, which in its recommendations supports our Guild policy since 1925.

To quote CR17: **"A Statute prohibiting any physician from referring to a service which he, his partners, or his family have a fiduciary interest should be proposed.**

In a Congressionally mandated study of medical business practices, the United States Department of Health and Human Services found that when patients saw physicians who had a financial interest in independent clinical laboratories, they received 45 percent more laboratory services. In order to contain costs, while ensuring that patients do not receive inappropriate care, it may be necessary to prohibit physicians from referring patients to services which they, their partners, or family have a fiduciary interest. While the federal government has enacted legislation in this area, it will apply only to Medicare patients referred to clinical laboratories."

With the increase of Doctor Dispensing in New Jersey, many of our members are being forced out of business, despite the recent passing of the so-called "Disclosure Law".

Unfortunately, some eye specialists seeking to circumvent the Disclosure Law, have developed business deals, often involving excess rentals and other similar dubious arrangements. Such developments are forcing many Guild Opticians out of business.

It is now, and always has been, our deeply held belief that it is the patient's needs and wishes which are paramount, not the financial advantage of the prescriber.

106X

The New Jersey patient-consumer should enjoy complete freedom to patronize the optician of his choice, after he has secured his prescription from the eye doctor. The patient must not be "steered", manipulated, or coerced in any manner in selecting eyewear of his choice, from an optician of his choice.

Respectfully submitted,

Coalition of Opticians

November 14, 1990

Mr. Chairman and Comittee members:

May we first emphasize that the legislation we seek in New Jersey has already, to a limited degree, been put into effect at the federal level, in connection with Medicare patients referred to clinical laboratories. (See quotations of CR17 in this letter below)

The principal, the effective significance, of the legislation we support has been accepted; the vital importance of the principal of Separation of prescriber from supplier (dispenser) which in our case involves eyewear, has already been recognized at the federal level in the matter of Medicare patients referred to clinical laboratories, i.e. prescriber and supplier must be separate entities.

We basically maintain that those same conditions, which warranted specific legislation to control, apply with equal force in New Jersey for the protection of New Jersey patient-consumer.

Further to clarify and emphasize our position, we quote in full Section CR17 from the recent publicized Governors Commission on Health Care Costs, submitted October 1, 1990.

To quote CR17: **"A Statute prohibiting any physician from referring to a service which he, his partners, or his family have a fiduciary interest should be proposed.**

In a Congressionally mandated study of medical business practices, the United States Department of Health and Human Services found that when patients saw physicians who had a financial interest in independent clinical laboratories, they received 45 percent more laboratory services. In order to contain costs, while ensuring that patients do not receive inappropriate care, it may be necessary to prohibit physicians from referring patients to services which they, their partners, or family have a fiduciary interest. While the federal government has enacted legislation in this area, it will apply only to Medicare patients referred to clinical laboratories."

We believe CR17, and specifically its final two sentences, definitely prove that the basic purpose of our separation argument, in respect to doctors and clinical laboratory relations under Medicare, has been accepted at the federal level.

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108X

Our specific legislation proposed has now been clearly identified and proposed as action "which may be necessary" in the CR17 section of the Governor's Commission.

We submit that such evidence, from the sources mentioned, constitutes overwhelming support for our position on the need for fundamental, complete legislative action separating once and for all, prescribing from dispensing.

Analysis of voluminous Medicare records, readily available, provide overwhelming proof of flagrant and long continued over-prescribing and the writing of unneeded prescriptions, when prescribing and dispensing coexist.

Medicaid records in New Jersey have revealed ~~that~~ virtually that most patients examined received eyewear prescriptions and eyewear annually.

Contrast this with comparable records of private practice, non-dispensing doctors. These reveal in startling contrast that the actual percentage of truly needed prescriptions to patients vary from 40 to 60 percent of patients examined, on a two year (not annual) basis. The 40 to 60 percent variation is attributable to the varying ages of patients examined.

Analysis of the three major systems of examination, prescribing, and dispensing, namely by independent non-dispensing eye doctors; Medicare, and Medicaid examining and dispensing where these coexist, reveal clearly the costly, wasteful fact:
The general public, and ultimately all taxpayers, thru various forms of insurance, are paying exorbitantly for unneeded services and materials, when the doctor both prescribes and supplies eyewear to Medicare and Medicaid patients.

This Conflict of Interest arrangement of combined prescribing and dispensing is multiplying in cancerous fashion, wastefully and steadily driving up insurance costs, the cost of insurance purchases, and the cost in taxation to support these programs.

Respectfully submitted

HFMA
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
NEW JERSEY CHAPTER
JOHN A. FORSMAN JR PRESIDENT
REPLY TO
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99 HIGHWAY 37 WEST
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November 19, 1990

Senator Richard Codey, Chairman
Senate Institutions, Health & Welfare Committee
State House Annex, CN-068
125 West State Street
Trenton, NJ 08625-0068

Dear Senator Codey,

Our organization has reviewed the Final Draft of the Regulatory Reform Recommendations as adopted by the Commission on Health Care Costs. It appears that the Commission, in their recommendations, wishes to simplify the current reimbursement system. Based upon our review we believe that many of the recommendations will, unfortunately make the current system even more complex. Many of the recommendations are well-meaning but would be next to impossible to implement. The goals outlined by the Commission are on a macro level. In order to be effective, we believe they must be studied on a micro level. It seems that many of the changes, if implemented, will adversely affect hospitals. We do not feel comfortable with many of the changes and strongly suggest there be a careful review and possible phase in policy so as not to unfairly place hospitals at serious financial risks. We also are concerned about the timing of and process by which changes will be made. There is no information in the Commission's recommendations about these two issues.

The ideas and concerns of the Healthcare Financial Management Association in regard to several of the proposals are detailed below.

MEDICAID REFORM

1. We support the expansion of the Medicaid Program. With respect to expansion of managed care (HMO, PPO) to Medicaid clients, we recommend mandatory elimination of discounts. In a controlled environment, encouragement of managed care cannot succeed unless the discount policy is eliminated. Maryland has implemented this type of discount restriction and we suggest New Jersey do the same. Should there be a need for reductions for managed care providers, we suggest this be accomplished through the payer differential in lieu of hospital-negotiated discounts. If the payer differential were to be reduced for HMOs then the payer differential for other payers would have to be increased. The payment balancing process of the system must be maintained.

110X

The participation of HMOs in the Medicaid Program can be very problematic especially as relates to registration and determination of eligibility. Other states have implemented similar policies which have resulted in numerous problems.

We support the recommendation for immediate on site eligibility determination. This would eliminate many operational and financial burdens incurred by hospitals, especially those with significant volumes of patients potentially eligible for Medicaid or charity care.

HOSPITAL RATE SETTING REFORM

1. We recommend utilizing financial and operational performance benchmarks similar to those incorporated into the Maryland System. The benchmarks should be New Jersey sensitive and intensity adjusted. The benchmarks should also include a target measure for reasonable operating margins which incorporates a statewide provision for such operating margins.

2. We agree that there is uncertainty in hospital rates. We have experienced extreme fluctuations in the mark-up factor due to the Department's inability to react to issues in a timely manner. The hospital industry would like to see the rates adjusted as infrequently as possible. Before setting rates for the year, prior year issues must be settled in order to avoid disastrous cash flow consequences. After prior year issues have been resolved, the recommendation to set hospital rates once a year will be successful only if either of the following occur:

A. Build anticipated rate changes into each hospital's rates. This is an option only if the anticipated rate changes can be accurately calculated.

B. Permit hospitals the ability to borrow funds from a short term pool (set up by the Financing Authority) and guarantee reimbursement of the resulting interest expense.

Historically, issues such as the Medicare shortfall, appeal items (specific and generic), CN approvals and DOH calculation errors have caused rates to fluctuate within the year. We suggest that hospital rates be set twice a year to adjust for these significant issues as they come up. As a

better alternative, we recommend allowing hospitals to bill controlled charges.

3. An all-inclusive payment rate has been recommended. We caution the Commission as to the complexity of the System. If a change to the indirect costs is warranted, it must be done carefully and with industry and payer input. Also it should be understood that the development of an all-inclusive rate will in no way make the System any less complex. It should also be noted that Medicare has tried to develop a totally all-inclusive rate and thus far has been unsuccessful.

We maintain that capital cost should be reimbursed as recommended by the JHPTF capital sub-committee and further that the sub-committee continue its work on improving capital reimbursement. It is imperative that there be guarantees for existing capital debt. We do find certain conclusions and recommendations of the Commission's report disturbing. In particular, is the annual cap on capital expenditures. Although no amount has been suggested, $200,000,000 has been used in an example. We think that this number is wholly inadequate because an average renovation and construction project runs approximately $50,000,000 per hospital. Limiting major capital construction to three to four hospitals a year will prevent New Jersey hospitals from upgrading their facilities in a timely manner.

We also strongly recommend the continuance of the current pass-through items. Costs such as collection agency fees and malpractice insurance premiums vary greatly within the industry from year to year. History has shown that subjecting these costs to "screens" is not appropriate and also ineffective in controlling costs.

The elimination of the guarantee of hospitals' financial solvency regardless of utilization and efficiency is very disturbing. This proposal runs contrary to one of the primary objectives of the Chapter 83 system.

4. The introduction of a 2% ...istment coupled with the elimination of several current... ...ovided adjustments (i.e., technology factor, operating marg... price level depreciation) does not balance. Hospitals ...ould actually experience

a decrease in approved revenues with this change. An adequate adjustment to the rates should be made which allows the industry to achieve an acceptable annual operating margin in the rate of 2-3%. It must also be adjusted each year as rates get further away from the base year costs. Another concern is that the 2% adjustment would apply only to "efficient" hospitals. There currently exists no definition of an "efficient" hospital. Therefore the adjustment would be subject to much interpretation and debate.

5. We support the movement towards the inclusion of more standard cost in the rates. However, the proposed CV/standard table, coupled with combining indirect and direct costs into one rate, may actually yield less of a standard rate. Again, the system is very complex and changes such as these must be coordinated with industry representatives and payers to ensure accuracy and adequacy.

6. The recommendation to implement the newly developed Yale Refined DRGs needs clarification. We request that an explanation of the Yale Refined DRGs be provided along with an impact analysis to facilitate review.

7. The recommendation for the HRSC to work with high cost or potentially insolvent hospitals should also apply to low cost hospitals. Hospitals operating at low cost who cannot maintain that low cost level, should be allowed to work with the HRSC to receive additional reasonable reimbursement. We are also concerned with the time that will be involved in this process. It is crucial that any review undertaken be completed quickly - no more than 150 days with a firm commitment from the Department to adhere to their schedule. At the moment, the system is unconscionably back-logged with appeals and final reconciliations. To prevent this from happening in the future, we suggest the DOH stagger time frames similar to the Maryland System. For example, ten hospitals could implement their rates on January 1, ten on February 1, etc. The same type of time frame could apply to appeals. This might enable the DOH to respond to hospitals within reasonable time frames.

8. The hospital industry strives to collect appropriate Medicare dollars. We disagree with the position that we are not maximizing the collection of Medicare reimbursement. We would like to see the evidence that points to significant undercollection by hospitals of Medicare dollars. Penalizing hospitals without such evidence is totally unacceptable.

9. With respect to reorganizing the HRSC, we agree that the complement of the HRSC needs to be changed. In light of the complexities of the hospital industry, perhaps full-time, salaried HRSC members are required. This could help relieve the backlog crisis and keep the current process on track. We oppose any recommendations that the Public Advocate have a voting seat on the HRSC. We strongly recommend that a hospital industry representative always be present in the HRSC especially so if a voting seat is provided to a payer representative. This would be necessary to provide a fair balance.

10. The recommendation to rebundle hospital-based specialists into the rates appears to have been made in an attempt to regulate physician fees. We oppose unequivocably this recommendation. It is unworkable, unreasonable and it will impair the relationship between the hospital and its physicians. The burden to control physician costs should not be placed on the hospital.

11. We agree that the patient bill must be understandable. We support billing charges (eliminating rates and payer factors on the bill) and maintaining a final reconciliation whereby hospitals would ultimately be reconciled to DRG rates.

HOSPITAL RATE APPEAL REFORM

1. In order to reduce the number of appeals, we suggest a greater incentive than is currently provided. For example, hospitals could be offered a 3% incentive (in lieu of 1%) for accepting their rates and waiving the right for all appeals. The 3% incentive should be viewed as a separate adjustment from the aforementioned adjustments.

2. We agree with setting a fixed dollar threshold for hospital appeals. However, the proposed threshold (sum dollar must exceed the annual target operating margin) is much too high. We do not believe the threshold should be tied to the hospital's operating margin.

3. We object to the proposal to hold any hospital's annual rate adjustments until that hospital's appeal is adjudicated. This proposal is punitive and unreasonable because the hospitals are not at fault for the current delays in the appeals

process. As mentioned previously, the implementation of staggered time frames may aid the DOH in responding more quickly to appeals.

4. We agree that outstanding appeals must be cleaned up and settled quickly. However, the proposed method to achieve negotiated settlements is unacceptable. Hospitals originally appealed under specific regulations in place at that time. To change the rules for appeal settlements retrospectively would be punitive. Interest costs must continue to be part of the settlements and hospitals should be given the opportunity to quantify the appeal issues. The qualifications of an administrative law judge would be aided by an education in hospital finance. We are concerned that introducing a new party (one who is not familiar with hospital reimbursement or its history) may not yield any type of efficiencies. The hospital should be allowed to invite parties it deems necessary to any proceeding.

To expedite final reconciliations we recommend the DOH contract with accounting/consulting firms (with appropriate cross checks). We object to limiting the adjustment to a two percent increase per year due to the already poor cash position of the industry. The entire settlement should be adjusted in the year it is settled. Hospitals wish to maintain stable billing rates. As an alternative, perhaps a cash pool could be used to give hospitals their cash at the time of the settlement. Only then could rate increases to payers be extended over a longer period of time, thereby stabilizing rates. The extended cash receipts (via rates) would then be forwarded to the cash pool.

UNCOMPENSATED CARE REFORM

1. We support the recommendation that funding for uncompensated care be done outside of the rates.

2. We oppose a fully prospective method of paying for uncompensated care. As a matter of state policy, New Jersey has historically provided unlimited access to health care. If hospitals are not allowed to turn patients away then we cannot be expected to be at risk for the cost of their care. Uncompensated care is often outside our power to control and cannot be accurately predicted. Any methodology utilized for uncompensated care reimbursement must not put the hospital at risk in an all payer system.

OTHER REGULATORY REFORM

A recommendation has been made that Physicians be prohibited from referring to a service in which he/she has an interest. We see this as seriously counterproductive. It would inhibit, if not preclude, the development of joint ventures which reduce demands for hospital borrowing, spread risk, and provide a means to cost effectively and quickly respond to emerging needs. We believe that full disclosure of interests and providing information on alternative services should be sufficient.

CERTIFICATE OF NEED APPLICATIONS

A recommendation was made concerning the definition of a health care facility. It was recommended that it should be changed to include under certificate of need requirements any services which are the subject of a State-adopted health planning regulation or any service or acquisition with a total project cost exceeding $1 million.

We caution the Commission that such a change could result in higher healthcare costs due to a reduction in competition. This could also raise new questions as to the reimbursement of uncompensated care for such facilities. At present, these facilities are at risk for bad debts and free care. If they become regulated, the State may also become responsible for indigent patients.

In summary, we request that before any final regulations are proposed that industry representatives be given a chance to provide input. We stand ready to assist in the process at your convenience.

Sincerely,

John A. Forsman

John A. Forsman
President, HFMA

JAF/bf

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Testimony

November 14, 1990

SENATE INSTITUTIONS, HEALTH & WELFARE COMMITTEE

Public Hearing

By: Carol J. Kientz, R.N., M.S.
President
Home Health Assembly of New Jersey

Prepared 11/14/90

117X

POSITION STATEMENT: REPORT OF THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS (10/1/90)

The intent and basic conclusions of the Commission Report have to be supported by health care providers concerned about the unmet health care needs of the uninsured and inadequately insured. For years the New Jersey home care provider community has been voicing its concern for the "no care zone" - the elderly and disabled, as well as the acutely ill, who cannot afford any long-term, maintenance, or acute care, let alone the right to choose where and how they want to receive the care.

The recognition by the Commission of the appropriateness and cost-effectiveness of home care to meet 1) chronic long term care needs; 2) a variety of acute needs including care of people with A.I.D.S.; and 3) compassionate family-oriented terminal care is indeed satisfying. Home care advocates are no longer "prophets crying in the wilderness". The home care industry is committed to working together with the Commission and the legislature to make home care available to every New Jersey citizen who wants and needs this economical and humane alternative. It should be noted that the cost-effectiveness of home care is further enhanced by the fact that its roots lie in preventive health care, and its goal is always maximizing the potential of the individual and family for self-care and independence. Finally, community health nurses traditionally provide the patient not only with treatment services, but with health education and over-all family health assessment and case-management, as well. Therefore, the Commission's recognition that some health care may be more appropriately and economically delivered by skilled nursing professionals is also a de facto

endorsement of the essential system of home health care in this State.

That being said, it must be noted, however, that there are unique aspects of the home care industry in New Jersey which make the proposed funding methods for totally insuring our population difficult to resolve and in need of study.

One of the most significant facets of home care is home health aide services. Homemaker-home health aides are employees at the low rung of the pay scale, to a large extent because Medicaid and Medicare reimbursement is inadequate. In fact, Medicaid rates in New Jersey are about 25% <u>below the cost</u> for provision of aide services by licensed, certified home care agencies. Therefore, benefits provided by home care employers are minimal or non-existent in many cases.

These employers would be delighted to provide the benefit of health insurance, but only if rates can be increased to adequately cover costs. As it is, many home care providers in New Jersey and all over the country are beginning to restrict the amount of care they give to Medicaid clients - they simply have no choice if they are to keep their door open.

This problem is further complicated by the fact that home health aides are largely per diem employees, many of whom work for multiple employers. Any type of mandatory employer insurance would need to identify mechanisms to apply this regulation fairly when the employee in a given week may work 3 hours for three days for employer A, 4 hours , five days for employer B, and 8 hours, one day for employer C - then the next week totally change this pattern, or work not at all for a week or two. Since this is a

common pattern of home health aide employment, this is understandably a major concern of the industry.

It may well be that opening up the state's Medicaid eligibility to low income employees could help resolve this problem, while also having the advantage of Federal matching funds. Opening the Garden State Health Plan may be another feasible alternative, though the plan's current pace of enrollment of Medicaid recipients call into question when, if ever, it will be prepared to enroll a whole new level of individuals. Some type of cost-effective industry self-insurance, coupled with raising Medicaid home care reimbursement rates to a cost-based level with appropriate annual adjustments is also a concept worth investigating.

Finally, while the home care provider community applauds the concept of case-managed health care, it does so with a strong caution. Case management is only as good as the individual case manager. The best constructed system falls apart when the case manager is not adequate to fill the role. Designing an individualized, patient/family centered care plan which maximizes family talents, patient independence, & creative use of community resources, while also utilizing the most cost-effective levels and loci of care which, in addition, are the most medically-safe and appropriate, requires the skill of an experienced health care professional familiar with all available modes of care, resources, and patient/family assessment methods.

Cases in point exist right here in New Jersey. Medicaid waiver programs, including A.C.C.A.P. and C.C.P.E.D., are case-managed. When those managers are experienced professionals such

as community health nurses, we have seen case management which is nothing short of brilliant in terms of both safe, effective, economical care and client satisfaction. However, in the instances in which inadequately prepared and inexperienced individuals acted as case managers, significant failures to address client needs were evident. Fortunately, these latter have been in the minority.

From the standpoint of private Health Maintenance Organization case management, there are also successes and failures - at least in terms of meeting clients' needs. The home care industry, nationwide, has even found it necessary to sue Medicare-eligible H.M.O.'s to force their compliance with Federal regulations stipulating that they must provide the care needed by the individual. Such suits have unfortunately been needed because many H.M.O.'s believe that the most cost-effective care is little or no care.

Thus the trend toward managed-care, while very appropriate, must be combined with safeguards to protect client safety and insure use of capable case managers.

To summarize, though there is unquestionable support for a method to adequately insure the health care needs of every New Jerseyan, while also redirecting health care toward cost-effective, client-preferred alternatives including home health care, there are also concerns unique to the home health care industry which must be resolved if the industry is to provide the amount and quality of care potentially needed in such a health care system. Those concerns include large numbers of uninsured per diem individuals, often working for multiple employers, and inadequate state home care reimbursement rates making is impossible to provide

universal employee benefits at these rates. Additionally, there is a need to guarantee adequate safeguards for any case-managed health care system. These concerns are not insurmountable, and the time is right to resolve them and make progress toward a fair and comprehensive health care system for New Jersey.

Carol J. Kientz
10/23/90

122X

NOVEMBER 14, 1990

TESTIMONY TO THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE ON THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS.

LOIS B. YATES ON BEHALF OF RITE AID CORPORATION

I am here to address the problem of out of control drug costs in the PAAD program as well as the need to facilitatte the use of generic drugs for the general public through Senator Cody's bill, S-1272, which has the "brand medically necessary requirement when prescribing prescription drugs.

Culkin and Mendell of the New Jersey Department of Health wrote, "if prescriber disapproval of generic substitution were decreased to even 10% in N.J., state wide consumer savings would increase by approximately $19 - 29 million dollars annually. This is if generic substitution is increased by 10%! They also cited an estimated savings of approximately $7 million by the 1985 N.J. medicaid program and approximately $7 million by the 1986 N.J. PAAD program. If you look at the average payment per recipient in 1986 it was $351.00 verses $611.00 in 1990. If $7 million could have been saved in 1986, think what could be saved if all drugs that can be substituted for generic were. I can only guess by using the 1986 figure that the 1990 savings would far exceed twice that.

Pennsylvania signed legislation similar to Senator Cody's bill two and a half years ago and they saved 30 million in the first year. At least 29 states have passed this legislation.

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N.J. is a large pharmacutical manufacturing state, and you may be hearing from some pharmacutical manufacturing companies that this legislation might cause potential health risks for N.J. consumers. As patents on some best selling prescription drugs expire, the makers have turned on a propaganda war against their generic competitors in order to insure you keep paying top dollar. Of all the generic drugs used in the U.S. today, at least 60% are sold by brand name companies. In addition, generic products are subject to the same FDA standards as brand name products.

NJPIRG, recently did a study on prescription drug costs and found that on the average, brand name drugs cost 54% to 233% more than generic drugs for the same strength and quanity of drugs surveyed. Here are two examples. Valium, one of the most widely prescribed drugs on the market, costs on an average of $42.47 for 100, 5mg of the name brand. If the generic brand is used, the average price is $12.74 for 100, 5mg tablets. 100, Tylenol 3 tablets cost $23.75 verses $12.73 for the generic brand.

N.J. currently has a statutory provision concerning generic substitution. The Drug Utilization Review Council (DURC) is to determine the therapeutic equivolency of putative generic substitution for branded products. A generic substitution formulary, listin acceptable generic products is to be prepared and distributed without charge to all prescribers and pharmacists. So you see N.J. has oversight in this area.

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In summary, this is one area that we can painlessly plug up the hole of money being wasted. I hope The committee will consider acting immediately on mandading generic substitution in the PAAD program as well as Senator Codey's bill, S-1272.

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November 12, 1990

Senator Richard Codey, Chairman
Senate Institutions, Health and
Welfare Committee
State House Annex
Trenton, New Jersey

Re: November 14th Public Hearing

Mr. Chairman & Members of the Committee:

As President-Elect of the New Jersey Chapter of the American College of Surgeons, I am pleased to present our views on the report of the Commission on Health Care Costs.

PLANNING PROCESS: The report recommends an increased State planning function and we feel physician representation should be provided for on the State Health Planning Board and Local Advisory Boards. We see no need for placing solo practitioners under Certificate of Need legislation. This could be a waste of State funds. If there is a specific problem behind this, legislation should address it directly and not punish all practitioners who are uninvolved, to solve one matter in question.

PHYSICIAN REFERRAL: A recent New Jersey law (1989) mandates physicians inform all patients if they have a significant interest in any referral, and we believe this disclosure law is sufficient, rather than more restrictive legislation.

ON-SITE ELIGIBILITY: The concept of supplying hospitals and health institutions with electronic data links to process Medicaid eligibility with a short form application ought to be investigated. This idea could possibly solve some hospital deficit problems.

EXPAND MEDICAID: We agree with the concept of expanding Medicaid to include more eligibles to reduce the number of those New Jerseyans without coverage. Yet, the concept of extending Medicaid beyond health care to assist in obtaining high school diplomas might bankrupt the program. It could even require a "Medicaid Waiver" to provide such coverage under national matching funds dedicated to health care.

MEDICARE BALANCE BILLING: Medicare fees now are below Usual Reasonable and Customary and there has been no cost-of-living increase in years. As a matter of fact, there have been cuts under Gramm-Rudman legislation and congress adopted further cuts for next year. Why should physicians alone subsidize Medicare by denying them the right to balance bill those patients who can afford to pay the Usual, Reasonable and Customary area fee. Medicare law places MAAC limits on physician's fees. In a free society, fees should be negotiated between the user and provider of services, and not arbitrarily set by a third party. The State so limiting a national program has no precedent in New Jersey. When national legislators promise a program and underfund it, it is not the State's obligation to supply a remedy. Indeed, we should all ask national legislators to shoulder their responsibility.

Many of our physician members participate in the State-wide Voluntary Medical Courtesy Program to provide private medical care for the elderly who might otherwise forego seeking medical care for financial reasons. These physicians have agreed to participate and accept assignment for their services for all seniors enrolled in the program. Those citizens which the State accepts on their PAAD program are automatically eligible and some others with higher income levels may also qualify.

STUDENT LOAN FORGIVENESS: To forgive State student loans if providers work in medically underserved areas is a good idea.

MANAGED CARE: The Commission report proposed under Medicaid "managed care,"the establishment of a formal system of provider relations and monitoring. This would require many more State employees and be an expensive new department. No definition of managed care is given. Hopefully, it will include free choice of physician, and a physician under managed care will have the choice of treatment without restrictions or impediments which would frustrate or disrupt quality patient care.

BASIC BENEFITS: To define a basic benefits package for health insurers seems to have merit if extended care packages can be written above basic coverage. The public now thinks they are covered for more than they are and can face unpleasant surprises when hospitalized unless benefits are clearly defined.

COURT SYSTEM REFORM: The recommendation for structured settlement legislation is one that will go a long way toward cutting health care expenses and cost to insurers and patients.

THE R.N. SHORTAGE: We go further than the report and consider New Jersey to have a nursing crisis. OUR POSITION: Future quality medical and health care depends on a continuing solid core of competent nurses in sufficient number to provide necessary bedside care.
We hope you will investigate proposed solutions to the nursing crisis which include: Salary adjustments, resurrecting three-year nursing schools, hospital schools, state and private funding for nurse scholarships and loans, nurse managerial training programs, cutting State duplicative bureaucratic paperwork requirements, nurse resource centers providing information for potential nurse candidates, and accelerated mass media campaigns to promote nursing as an exciting, rewarding career.

We thank you for this opportunity to express our views as health professionals dedicated to providing quality patient care. We respectfully request that organizations representing physicians be contacted for representation in the future, so that a broad spectrum of community views sit at the table when planning for health care.

Sincerely yours,

William C. Rainer, M.D.
President-Elect, New Jersey Chapter
American College of Surgeons

WCR/ggh

New Jersey Pharmaceutical Association

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NOVEMBER 14, 1990

STATEMENT TO THE SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
BY THE NEW JERSEY PHARMACEUTICAL ASSOCIATION
ON THE REPORT OF THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS.

MY NAME IS LEON LANGLEY AND I REPRESENT THE NEW JERSEY PHARMACEUTICAL ASSOCIATION WHICH IS THE PROFESSIONAL SOCIETY OF PHARMACISTS IN NEW JERSEY, WITH ABOUT 3,500 PHARMACIST MEMBERS. WE WELCOME THIS OPPORTUNITY TO PRESENT OUR CONCERNS ON THE COMMISSION REPORT TO THIS COMMITTEE. MY COMMENTS WILL CONSIST OF TWO PARTS, THE FIRST PART BEING GENERAL COMMENTS ON THE COMMISSION REPORT AND SECONDLY I WOULD LIKE TO EXPLAIN HOW THE RECOMMENDATIONS CONTAINED IN THE REPORT WILL AFFECT PHARMACY SERVICES IN NEW JERSEY.

THE OVERALL FEELING ONE GETS FROM READING THE REPORT IS THAT ALL HEALTH CARE SERVICES SHOULD BE MOVED INTO THE MANAGED CARE CONCEPT BASED ON THE COMMISSIONS APPARENT BELIEF THAT MANAGED CARE SYSTEMS IMPROVE "WELL CARE" AND REDUCE THE COST OF "SICK CARE". WE BELIEVE THE PROOF OF THAT CONCEPT IS NOT YET IN. PLEASE KEEP IN MIND THE FACT THAT MANAGED CARE SYSTEMS CREATE LARGE ADMINISTRATIVE EXPENSES NOT DIRECTLY RELATED TO HEALTH CARE. IT COULD BE THAT IMPLEMENTING THE COMMISSION'S RECOMMENDATIONS TO TAKE ALL NEW JERSEY CITIZENS INTO MANAGED CARE HEALTH SYSTEMS WILL ONLY TRANSFER SCARCE HEALTH CARE DOLLARS INTO ADMINISTRATIVE EXPENSES WITHOUT CONTROLLING THE RAPID ESCALATION OF HEALTH CARE COSTS. HEALTH MAINTAINANCE ORGANIZATIONS ARE A RELATIVELY NEW

PHENOMENON WHICH USE LOW PREMIUMS TO GAIN MARKET SHARE. A RECENT SURVEY OF HMO'S INDICATES THAT THEY INCREASED THEIR PREMIUM CHARGES BY AN AVERAGE OF 17% EACH YEAR DURING 1988 AND 1989. WE SUGGEST THIS COMMITTEE SHOULD CLOSELY LOOK AT ADMINISTRATIVE COSTS IN EXISTING HMO'S, AND AT THE POSSIBILITY OF RAPIDLY ESCALATING PREMIUMS, BEFORE EMBRACING THE MANAGED CARE CONCEPT FOR EVERYONE.

WE ALSO SUGGEST THAT THIS COMMITTEE SHOULD LOOK AT HEALTH CARE RATIONING PRACTICES EMPLOYED BY MANY HMO'S TO CONTROL THEIR COSTS. WE UNDERSTAND THAT MANY HMO'S ESTABLISH "NORMS" FOR THE ORDERING OF SUCH PROCEDURES AS VARIOUS DIAGNOSTIC TESTS, AND THAT PHYSICIANS ARE PRESSURED BY MANAGEMENT TO STAY WITHIN THE NORMS REGARDLESS OF THE PATIENTS' NEEDS. MANY HMO'S ALSO RESTRICT THE DRUGS THAT ARE AVAILABLE TO ENROLLEES BY ESTABLISHING RESTRICTED DRUG FORMULARIES FROM WHICH THE PHYSICIANS ARE NOT ALLOWED TO DEVIATE AGAIN, REGARDLESS OF THE PATIENTS' NEEDS. WHILE THESE RESTRICTIONS MIGHT BE ACCEPTABLE TO MANY PEOPLE, WE BELIEVE INFORMATION REGARDING RESTRICTIONS PLACED ON MEDICAL PRACTICE BY HMO MANAGERS SHOULD BE MADE AVAILABLE TO ENROLLEES SO THEY CAN MAKE AN EDUCATED CHOICE OF WHETHER THEY WANT TO ACCEPT, OR NOT ACCEPT THESE RESTRICTIONS.

THERE WERE TWO ITEMS NOT MENTIONED IN THE COMMISSION REPORT WHICH WE BELIEVE ARE MAJOR ITEMS. ONE IS DUPLICATE HEALTH CARE PREMIUM PAYMENTS WHICH ARE PAID TO INSURANCE COMPANIES BY EMPLOYERS ON BEHALF OF EACH MEMBER OF A WORKING MARRIED COUPLE, WITH BOTH HEALTH INSURANCE POLICIES COVERING THE SPOUSE AND ANY CHILDREN. WE ARE DISTURBED BY THE FACT THAT THE COMMISSION APPARENTLY DID NOT LOOK INTO THIS PRACTICE WHICH WE BELIEVE ADDS TO HEALTH CARE COSTS. THE SECOND ITEM NOT MENTIONED IN THE COMMISSION REPORT IS THAT OF A SIGNIFICANT CO-PAYMENT BY PATIENTS FOR HEALTH CARE SERVICES RECEIVED. VARIOUS STUDIES INDICATE THAT A SIGNIFICANT CO-PAYMENT, PERHAPS IN THE 20% RANGE, MAKES HEALTH CARE CONSUMERS INTO PRUDENT BUYERS. WE BELIEVE A SIGNIFICANT CO-PAYMENT FOR EACH HEALTH CARE SERVICE RENDERED WOULD SIGNIFICANTLY REDUCE UNNECESSARY UTILIZATION. WE SUGGEST THAT THIS COMMITTEE

MIGHT INVITE HEALTH CARE ECONOMIC EXPERTS TO TALK TO YOU PRIOR TO THE DEVELOPMENT OF ANY LEGISLATION REGARDING THE EFFECTS A SIGNIFICANT CO-PAYMENT WOULD HAVE ON UTILIZATION.

THE COMMISSION REPORT RECOMMENDS THAT ALL MEDICAID PATIENTS BE MANDATED INTO THE GARDEN STATE HEALTH PLAN. WE BELIEVE THAT PLAN IS SERIOUSLY FLAWED AND IT WILL NOT RESULT IN ANY SIGNIFICANT CONTROL OF HEALTH CARE COSTS. THE PLAN IS SET UP SO THAT A GATE KEEPER PHYSICIAN IS PAID X NUMBER OF DOLLARS A MONTH TO MANAGE A PATIENT AND ANY HEALTH CARE SERVICES THE PHYSICIAN ORDERS IS CHARGED AGAINST HIS MONTHLY PAYMENT. IN THE AREA OF PRESCRIPTION DRUGS WE BELIEVE THIS PRACTICE IS VERY SIMILAR TO PHYSICIANS SELLING DRUGS FOR PROFIT TO THEIR PATIENTS AND IS A STRONG DISINCENTIVE FOR PHYSICIANS TO PRESCRIBE THE BEST DRUG FOR A PARTICULAR PATIENT'S MEDICAL CONDITION. THE PLAN BASICALLY PITS THE GATE KEEPER PHYSICIAN AGAINST OTHER PRIMARY HEALTH CARE PROVIDERS WHILE NOT TAKING INTO ACCOUNT THE MAJOR COST OF THE MEDICAID PROGRAM, WHICH IS THE COST OF INSTITUTIONALIZING A PATIENT. THE CURRENT YEAR'S MEDICAID BUDGET, PAGE D-241, SHOWS THAT THE COMBINED COST FOR PHYSICIAN SERVICES AND PRESCRIPTION DRUGS IS $209,000,000.00 WHILE INSTITUTIONAL COSTS, I.E., NURSING HOMES, HOSPITALS INPATIENT, AND HOSPITAL OUTPATIENT SERVICES, COST ONE AND A HALF BILLION DOLLARS . THE COMBINED COSTS OF THOSE TWO OUTPATIENT SERVICES IS ONLY 14% OR 15% OF THE COSTS OF INSTITUTIONAL SERVICES. WE SUGGEST THAT THE PATIENTS, AND THE BUDGET, WOULD BE BEST SERVED IF THE BASIC CONCEPT OF THE GARDEN STATE HEALTH PLAN WAS CHANGED SO THAT PRIMARY HEALTH CARE PROVIDERS, SUCH AS PHYSICIANS, HOME HEALTH CARE AGENCIES, AND PHARMACISTS, WORK TOGETHER AS A TEAM TO IMPROVE HEALTH CARE FOR THESE PATIENTS AND TO PREVENT INSTITUTIONALIZATION.

WE ALSO NOTE THAT THE COMMISSION REPORT RECOMMENDS THAT ALL EMPLOYERS BE REQUIRED TO SUPPLY A "BARE BONES" HEALTH BENEFIT TO ALL EMPLOYEES. WE DO NOT BELIEVE A BARE BONES HEALTH CARE POLICY COULD BE DEVELOPED, AND IF IT IS BORN IT WILL NOT LIVE LONG. THIS LEGISLATURE IS MUCH MORE HUMANE THAN THAT. WE

NOTE THAT THERE ARE NUMEROUS BILLS MOVING THROUGH THE LEGISLATURE NOW WHICH MANDATE INSURERS TO PAY FOR ADDITIONAL HEALTH CARE ITEMS, SUCH AS MAMMOGRAMS AND INSULIN SYRINGES AND NEEDLES. WE ALSO NOTE THIS LEGISLATURE'S RESPONSE EARLY THIS YEAR OR LATE LAST YEAR WHEN A LITTLE GIRL WAS DENIED COVERAGE FOR A LIFE SAVING BONE MARROW TRANSPLANT PROCEDURE AND THE INSURER SAID IT WAS EXPERIMENTAL AND REFUSED TO PAY. YOUR ACTIONS IN THAT CASE WERE RIGHT, BUT IT WAS A $100,000 PROCEDURE. WE BELIEVE YOU WILL HAVE EXTREME DIFFICULTY IN IDENTIFYING A BARE BONES HEALTH CARE POLICY.

MORE SPECIFIC TO PHARMACY PROBLEMS, WE HAVE TWO SERIOUS PROBLEMS WITH HEALTH SERVICES DELIVERED THROUGH MANAGED CARE SYSTEMS AND THROUGH SUCH LARGE PHARMACY SERVICE PROVIDERS AS MAIL-ORDER PHARMACIES. NUMEROUS HMO'S RESTRICT THEIR ENROLLEES TO OBTAINING THEIR PRESCRIPTION NEEDS FROM A SELECT FEW PHARMACIES. ALL OTHER PHARMACIES ARE EXCLUDED FROM SERVICING THESE ENROLLEES. WE CALL THIS PRACTICE "CLOSED PANEL PHARMACY PROVIDER SERVICES". THE PRACTICE IS EXPANDING AND IT HAS THE POTENTIAL OF CLOSING MANY SMALLER COMMUNITY PHARMACIES THROUGHOUT THE STATE. IN ADDITION, WE BELIEVE THIS PRACTICE IS ILLEGAL IN THAT A SECTION OF THE PHARMACY ACT PROHIBITS THE LICENSURE OF ANY PHARMACY WHICH ENTERS INTO ANY AGREEMENT WHICH DENIES THE PATIENT THE RIGHT OF FREE CHOICE OF PHARMACIES (SECTION 45: 14-33.E.). LAST JANUARY WE CALLED THIS PRACTICE TO THE ATTENTION OF THE NEW JERSEY BOARD OF PHARMACY AND NOW, 11 MONTHS LATER, WE HAVE NOT RECEIVED WORD ON WHETHER THEY ARE GOING TO ENFORCE THE LAW. WE WOULD ASK YOUR HELP IN CONVINCING THE BOARD OF PHARMACY TO ENFORCE THAT SECTION OF THE PHARMACY ACT AND WE ALSO ASK YOU TO ALLOW ALL PHARMACIES THE OPPORTUNITY TO PARTICIPATE IN SERVICING MANAGED CARE ENROLLEES WHEN YOU ARE DEVELOPING LEGISLATION ON THIS SUBJECT.

WE BELIEVE THE EXCLUSION OF SMALLER PHARMACIES FROM PARTICIPATION IN THESE ORGANIZED PLANS, AND THE COMPETITION WE ARE FACING FROM MAIL-ORDER PRESCRIPTION PHARMACIES, IS BASED ON THE FACT THAT MANY MAJOR DRUG COMPANIES ARE SUPPLYING DRUGS TO THESE PHARMACIES AT DISCRIMINATORY LOW PRICES.

COMMUNITY PHARMACIES AND OUR PATIENTS ARE FACING SEVERE PROBLEMS DUE TO THE RAPIDLY ESCALATING COSTS OF PRESCRIPTION DRUGS. PHARMACISTS ARE BLAMED BUT WE HAVE NO CONTROL OVER MANUFACTURES PRICES. WE BELIEVE THAT ONE OF THE REASONS THAT PRESCRIPTION DRUG MANUFACTURES INCREASE THEIR PRICES SO RAPIDLY IS THAT THEY ARE MAKING UP FOR REDUCED INCOME WHEN THEY GIVE SPECIAL LOW PRICES TO SPECIAL PHARMACIES, PHARMACIES WHO ARE IN DIRECT COMPETION FOR PATIENTS WITH REGULAR COMMUNITY PHARMACIES. WE BELIEVE THAT DRUG MANUFACTURES MAKE UP FOR THIS LOST PROFIT THROUGH DOUBLE DIGIT INFLATIONARY PRICES WHICH ARE PAID BY DRUG CONSUMERS WHO ARE NOT INVOLVED IN THESE SPECIAL GROUPS. PATIENTS PAYING TOP DOLLARS FOR PRESCRIPTION DRUGS INCLUDE ALL SENIOR CITIZENS, INCLUDING THOSE WHO ARE COVERED BY THE PAAD PROGRAM AND THOSE WHO ARE NOT, UNION AND EMPLOYER PRESCRIPTION PLAN ENROLLEES, AND, OF COURSE, THE MANY MANY NEW JERSEY CITIZENS WHO PAY FOR PRESCRIPTION DRUGS OUT OF THEIR OWN POCKETS. ALL OF THESE CONSUMERS ARE SUBSIDIZING THE SPECIAL GROUPS WHO ARE THE RECIPIENTS OF THESE LOW PRESCRIPTION DRUG PRICES. WE HAVE NO PROBLEM WITH HOSPITALS RECEIVING DRUGS FROM MANUFACTURES AT LOW PRICES. OUR MAIN PROBLEM IS THAT WE CANNOT MEET COMPETITION, AND MAINTAIN AN ORDERLY COMPETITIVE PRESCRIPTION DRUG MARKET PLACE, AS LONG AS PRESCRIPTION DRUG MANUFACTURES CONTINUE TO GIVE LOW, DISCRIMINATORY PRICES TO PHARMACIES WHO ARE IN DIRECT COMPETITION TO OUR TAX PAYING COMMUNITY PHARMACIES THROUGHOUT THE STATE. WE BELIEVE THE PRACTICE OF PRESCRIPTION DRUG MANUFACTURES SELLING THEIR PRODUCTS AT WIDELY DIFFERENT PRICES TO COMPETING RETAIL PHARMACIES IS UNFAIR TO THE "HIGH PRICE" PHARMACIES AND THE NEW JERSEY CITIZENS WHO UTILIZE THOSE PHARMACIES, AND IN FACT MAY BE AN ILLEGAL PRACTICE. WE DO ASK THIS COMMITTEE TO INVESTIGATE THE PRICING POLICES OF MAJOR PRESCRIPTION DRUG MANUFACTURES WITH THE INTENT OF HOLDING DOWN THE SPIRALING COST OF DRUGS FOR THE MAJORITY OF NEW JERSEY CITIZENS.

I THANK YOU FOR TAKING THE TIME TO LISTEN TO OUR COMMENTS TODAY.

UNION COUNTY MEDICAL SOCIETY OF NEW JERSEY

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BESSIE M. SULLIVAN, M.D.
DIPLOMATE OF THE AMERICAN BOARDS OF:
INTERNAL MEDICINE, RHEUMATOLOGY
ALLERGY AND IMMUNOLOGY

November 14, 1990

The Honorable Richard J. Codey
Chairman, Senate Institutions, Health and
Welfare Committee
State House Annex, CN-068
Trenton, NJ 08625

Re: Public Hearing Commission
on Health Care Costs

Members of the Committee:

We commend the Commission on its in-depth study of the important issues in health care. The issues are many and cannot be fully addressed in this limited time. Our remarks are confined to concerns regarding the Uncompensated Health Care Fund, health insurance, and social fiduciary responsibility.

We feel that the issue of the Uncompensated Care Trust Fund is the most critical. We suggest that a subcommittee be formed comprised of members of the business community, medical society, and consumers to address the impact of the Committee's recommendations on businesses in the state.

The Governor's Commission has proposed spreading the cost of the Uncompensated Care Trust Fund over a larger segment of the New Jersey population by imposing a $144 tax per employee on employers and imposing a $1,000 penalty per employer on employers who do not provide basic health coverage. We agree that in order to make coverage available, the costs of coverage and the Uncompensated Care Trust Fund should be borne by a larger segment of the population, but it is necessary to review further the impact of this cost shift to the business community.

Pending the resolution of this, physicians will continue to care for indigent patients. It should be noted that physicians in New Jersey give patient care which is truly "uncompensated" since there is no fund to reimburse them.

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One of the long-term resolutions of the Uncompensated Care Trust Fund requires that the uninsured population be at minimum levels. Rather than expanding the Garden State Health Plan, we would encourage the private carriers to provide such coverage.

An issue which also must be considered concerns senior citizen care. We encourage the Commission to review the Senior Citizen Courtesy Program of the Medical Society of New Jersey. Through this program, the needs of the less affluent are addressed. Physicians accept assignment depending upon the income level of the senior citizen.

An additional point to be considered is the Commission report which encourages giving HMOs incentives for accepting Medicaid patients noting that physicians and providers are not fulfilling the need to see these patients. The paperwork involved in obtaining reimbursement is voluminous, and escalating. Also worthy of note is the reimbursement profile. Currently a physician is reimbursed $12-$16 for an office visit and $16-$35 for a home visit while a visiting nurse is reimbursed $54.30, a physical therapist $54.10, and a social worker $56.00 for a home visit.

Many physicians see Medicaid patients for no fee rather than wade through the considerable paperwork involved to obtain payment. More physicians might accept Medicaid patients if less time was involved in the paperwork and reimbursement rates were updated to approach current fees.

We take issue with the Commission's recommendation that managed care plans are preferable to traditional fee-for-service indemnity plans, and that only managed care programs be eligible for subsidies. Management care plans limit access and negatively impact the quality of patient care.

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ALLERGY AND IMMUNOLOGY

To: The Honorable Richard J. Codey
Date: 11/14/90
Page: 3

The economics of the health care industry must be reviewed. Cost containment should not simply be the burden of the hospital and/or physician. Ancillary industries must also realize their impact on medical economics.

In summary, the most pressing issue continues to be the indebtedness of the Uncompensated Care Trust Fund which must be addressed.

Bessie M. Sullivan, M.D.
President, Union County
Medical Society

BMS/bl

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November 10, 1990

Senator Richard J. Codey, Chairman
Senate Institutions, Health & Welfare Committee
New Jersey State Legislature
State House Annex, CN-068
Trenton, New Jersey 08625-0068

Dear Senator Codey:

I am writing to you concerning the recommendations of the Governor's Commisssion on Health Care Costs, and the upcoming public hearings on Wednesday, November 14, 1990. I have enclosed comments from our organization, the New Jersey Rheumatism Association, which were presented in formal testimony three and one-half years ago at the time mandatory fee participation was being considered by the New Jersey State Legislature. I thank you in advance for taking the time from your busy schedule to consider our comments.

Sincerely yours,

Arthur E. Brawer, M.D.

Arthur E. Brawer, M.D.
Assistant Clinical Professor
of Medicine, Hahnemann Medical
College (Phila, Pa.) and
Robert Wood Johnson Medical
School (New Brunswick, N.J.)

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May 11, 1987

To: Health and Human Resources Committee
New Jersey State Assembly
Trenton, New Jersey

From: New Jersey Rheumatism Association
Arthur E. Brawer, M.D. - President

Topic: Statement of Opposition to the Enactment of Assembly Bills 2511 and 3305

The remarkable achievements of our country over the past two-hundred years were often the result of people joining hands and working together. The members of the New Jersey Rheumatism Association are accustomed to holding hands every day of the week. The hands we hold are those of unfortunate arthritic patients, many of them elderly. The services we provide are obvious to all, whereby the bond of touching the patient is translated into the relief of despair. This bond is strengthened by the realization that the physician's concern, responsibility, and availability does not end when his patient has paid a bill and left the office. This bond is just as strong when compassion dictates voluntary Medicare assignment as payment in full for the truly needy patient. In addition, intense competition, and the large number of alternative medical care delivery systems currently at work in the marketplace, provide a favorable environment for the industrious patient seeking reasonably priced and competent care. Volunteer work by the physician in his hospital based clinic serves to amplify our availability.

Why is it then that the bond between physician and patient has developed a number of alarmingly weak links? Why is it that the physician has been placed in the unenviable position of being characterized as dishonest, incompetent, and uncaring? How is it that the best medical care in the world, which came about by linking licensure to stringent medical standards of ethics and ability to serve, would now replace expertise with forced fee participation as the gold standard? Each year we give more of ourselves than we did the year before, which is in large part based on continuing medical education to meet the demands of patients seeking the latest advances in medical care. Innumerable telephone calls, a mountain of paperwork, and stacks of x-rays often consume as much time as does the direct care of patients in the hospital, office, or home. Under these circumstances, can anyone truly devise a formula for physician compensation? The physician doesn't need a slide rule nor a computer to tell him when to be compassionate to the patient with limited financial means. Would patients continue to be willing to place their trust and faith in a physician who has been rendered apathetic, unmotivated, and complacent by misdirected and ill-conceived legislation?

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May 11, 1987
New Jersey Rheumatism
Association

Today's practicing physician is burdened with a variety of other steadily rising pressures. Although each is important in its own right, such as malpractice reform and increasing public scrutiny, we are confronted today by those whose tunnel vision would view the gap between fees and reimbursement as a singular isolated problem. It is not singular, and it is not caused by physician greed. This gap has its roots deeply intertwined in federal budgetary constraints, and in the resources the physician is forced to allocate during medical school training and the subsequent day to day running of his practice.

Perhaps the most important ramification of proposed legislation, such as bills 2511 and 3305, is the effect this is having on physician self-assessment. In some informal polls, less than ten percent of physicians in practice today would recommend medicine as a career for their children. The incentives to maintain any favorable and intellectual climate of medical practice are evaporating. This may have dire consequences for the availability of medical care for future generations. It reminds us of the potential future scenario of the patient who says, "doctor, noone listens to me when I talk," and the doctor says: "Next."

The New Jersey Rheumatism Association urges you to discharge your elected duties by honestly assessing all of the pros and cons of the legislation under consideration. We feel that a thorough assessment of the issues involved will lead you to conclude that defeat of these bills is in the best interest of the continuance of sound, well-meaning, and compassionate medical care in the state of New Jersey.

Respectfully submitted,

Arthur E. Brawer, M.D.
President, New Jersey
Rheumatism Association

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ARTHUR E. BRAWER, M.D., P.A.
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October 1, 1988

Curriculum Vitae

Date of Birth: April 5, 1947 - Paterson, New Jersey.

Marital Status: Married; two children.

High School: Asbury Park High School, Asbury Park, N.J. - graduated 1964.

College: Brandeis University, Waltham, Mass. - B.A. June 1968.

Medical School: Boston University School of Medicine, Boston, Mass. - M.D. May, 1972.

Internship: Straight Medical, Genesee Hospital, Rochester, N.Y. 7/1/72-6/30/73.

Residency: Straight Medical, Boston VA Hospital, Boston, Mass. 7/1/73-6/30/74.
Combined second year straight medical residency and first year Arthritis Fellowship, Boston City Hospital & Boston University Medical Center, 7/1/74-6/30/75.

Fellowship: Second year Arthritis Fellowship, Boston University Medical Center, 7/1/75-6/30/76.

Rheumatology private practice: Since August 9, 1976.

State Licensure: Massachusetts 10/73; New Jersey 2/76. (#s 35935 & 31088 respectively)

Board Certification: National Board of Medical Examiners, June 1973.
American Board of Internal Medicine, June 1975.
American Board of Rheumatology, October 1976.

Present Position: Attending Physician, Monmouth Medical Center, Long Branch, N.J. 07740.
Director of Rheumatology & Director, Arthritis Clinic, MMC.

Other Appointments: Assistant Clinical Professor of Medicine, Hahnemann Medical College, Philadelphia, Pa., & Robert Wood Johnson Medical School, New Br
Consulting Rheumatologist, Riverview Hospital (Red Bank, N.J.), N.J.
Bayshore Hospital (Holmdel, N.J.), Paul Kimball Hospital (Lakewood, N.J.

Society Memberships: Fellow, College of Physicians of Philadelphia.
Member: American Rheumatism Association, New Jersey Rheumatism Association, New York Rheumatism Association, New England Rheumatism Society, Philadelphia Rheumatism Association, N.J. State Medical Society, Monmouth County Medical Society, and Massachusetts Medical Society.
Vice-president, N.J. Rheumatism Association Nov.1982-Nov.1985.
President, N.J. Rheumatism Association, Nov. 1985 to present.

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October 1, 1988

Curriculum Vitae
(continued)

Publications: Brawer, Arthur E., M.D., "The Onset of Rheumatoid Arthritis Following Trauma," presented at the XVI International Congress of Rheumatology, Sydney, Australia, May 19, 1985-May 25, 1985.

Brawer, Arthur E., M.D., and Cathcart, Edgar S., M.D., "Acute Monocytic Arthritis" A&R, Vol22, #3, pp 294-300, March 1979.

Brawer, Arthur E., M.D., "Acute Migratory Polyarthritis" Todays' Clinician, Vol 1, #3, pp47-54, Nov/Dec 1977.

Brawer, Arthur E., M.D., "The 'Gold Standard' in Rheumatoid Arthritis," presented at the Northeast Regional meeting of the American Rheumatism Association, Boston, Mass., October 30-31, 1986.

Brawer, Arthur E., M.D., "The Combined Use of Oral Methotrexate and Intramuscular Gold in Rheumatoid Arthritis," presented at the Northeast Regional meeting of the American Rheumatism Association, Atlantic City, N.J., October 22-24, 1987.

Brawer, Arthur E., M.D., "Polyarteritis Nodosa: Treatment With Cyclophosphamide Alone," presented at the Northeast Regional meeting of the American Rheumatism Association, Atlantic City, N.J., October 22-24, 1987.

Brawer, Arthur E., M.D., "Polyarthritis and Pancytopenia in an Elderly White Male," presented at the Thieve's Market of the Northeast Regional meeting of the American Rheumatism Association, Atlantic City, New Jersey, October 22-24, 1987.

Brawer, Arthur E., M.D., "Anarthritic Rheumatoid Arthritis: The Polymyalgia Dilemma," presented at the Northeast Regional meeting of the American Rheumatism Association, Ottawa, Canada, Sept. 23-25, 1988.

NFIB New Jersey

National Federation of
Independent Business

NFIB/NEW JERSEY

TESTIMONY BEFORE

THE SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE

NOVEMBER 14, 1990

Presented by:
Laura Giannotta
Director, NFIB/New Jersey

State Office
156 W. State St.
Trenton, NJ 08608
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The Guardian of
Small Business

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Mr. Chairman, members of the Committee, I'm Laura Giannotta, New Jersey Director for the National Federation of Independent Business. I appreciate this opportunity to share with you the views of New Jersey's small and independent business owners on health care and health insurance.

By way of background, the National Federation of Independent Business (NFIB) is an umbrella business association representing nearly 600,000 small businesses across the country. Collectively small business members of NFIB employ about 7 million workers, with the average member employing 10 persons. In New Jersey, NFIB membership is nearly 9,000.

NFIB's prime mission is to be the most effective advocate of small business and to be the guardian of a competitive free enterprise system. Policy positions at NFIB are established through a vote of the general membership, not a board of directors or a select committee. Six times annually members are asked to vote on 5 policy issues through NFIB's federal office in Washington. New Jersey members are polled every fall and asked to express their opinions on issues particular to the Garden State. On the issue of government mandates and escalating health insurance costs, New Jersey's NFIB members have been vocal.

I must first point out that New Jersey residents are not denied access to health care nor are they denied access to health insurance. The state's Uncompensated Care Trust Fund and the role carved for Blue Cross/Blue Shield have assured the availability of hospital care and health insurance. The problem is not access, but affordability.

In one year the cost of employer medical plans increased 20.4%. A recent study by a Princeton based firm showed the average cost of a medical insurance plan rose from $2160 in 1988 to $2600 in 1989. Estimates are that by this time next year the average health insurance policy in this country will cost $3200.

Those national figures are supported by a recent survey of NFIB members in New Jersey. 97% reported insurance cost increases over the preceding 12 months. Nearly 30% of those employers polled experienced increases of 20%, while more than half saw their premiums double.

According to survey responses, the majority of the small and independent business owners in New Jersey provide health insurance. In 1987, 71% of our members provided this benefit. In 1989, 78% of the NFIB members responding offered insurance to employees and in 1990, responses indicated that 76% offered health insurance.

With these figures its hard to argue that small business is the culprit in the uncompensated care and uninsured problem. When affordable, and the individual economic situation allows, employers will provide this employee benefit, health insurance.

However, the present climate in New Jersey does not encourage this. Reduced consumer spending, dramatic employee cost increases and new taxes all point to a steep slide in the state's once thriving economy. This coupled with soaring health care costs and ever increasing insurance premiums make it difficult to plan for the provision of health insurance.

This is demonstrated in the responses to the 1990 Ballot question on providing health insurance. In 1989, 78% of the NFIB/New Jersey members said they provided health insurance as an employee benefit, compared to 76% in 1990. Most attribute this drop to the high cost of insurance and the instability of price.

There are other reasons that many lack health insurance, though I believe upon further examination it can all be boiled down to dollars and cents.

In New Jersey, the lack of health insurance is not a barrier to receiving health care. So what is the value? It is of value only to those who wish to protect their assets against catastrophic health care expenses. For those with few or no assets, the price of health insurance generally far exceeds its value.

Another reason many New Jersey residents go without insurance coverage or employers don't offer coverage is that state statutes and regulations prevent the purchase of policies tailored to individual and family needs.

In recent years there have been numerous state laws requiring that health insurance policies cover specific diseases and services. In 1970, there were only 30 mandated health insurance benefit laws in the country. At last count (February, 1988), there were 868 mandated benefit laws throughout the country. The enormous increases in health insurance costs can be tied to the proliferation of mandated coverages.

These legislative dictates prevent the offering of no-frills insurance at a reasonable cost. If our goal is to expand the number of residents with health insurance coverage and to encourage employers to assist in this effort we must allow flexibility in benefit plans. That alone would cut costs and make insurance more affordable to individuals and employers.

Surveys indicate the overriding issue for determining health care offerings by small employers is profitability. Small business has a well documented record as job creators, generating two out of every three new jobs over the last 5 to ten years. Contributing to their success has been their flexibility to mold the hours employees work and the degree to which they can tailor their benefit packages.

Mandating certain types of coverage eliminates this flexibility of benefit plan design. As a result a small employer

(unable to self insure) can't purchase what he/she needs at a price they can afford.

Small employers should be provided the same freedom from mandated benefit laws now enjoyed by large self insured employers. This mandated benefit exemption for small business is working in other states. I have attached to this statement two such legislative initiatives. (1a.)

A more stable and predictable marketplace that guarantees not the availability, but the affordability of health insurance is essential. Take for example one NFIB member who called my office this last month to relate his recent history with Blue Cross/ Blue Shield. In October, 1988 his quarterly premium for 8 employees was $5,888. In September of '89 the quarterly premium increased to $8,875 for those same 8 employees. In June, 1990 the bill for one quarter was $11,031. How does a business owner plan for that?

So the product is out there, but employers with high risk individuals or those engaged in high risk occupations can not obtain coverage as a group but must opt for the higher priced individual coverage.

A reinsurance mechanism, coupled with small group underwriting and a change in rating would help to alleviate these problems. First it would guarantee coverage to all groups, including groups with high risk individuals.

Second the reinsurance mechanism and some rating changes would combine to provide a more predictable and stable pricing structure for all small group policies. It would also make insurance more affordable to groups with persons who have existing medical conditions.

Another avenue to examine is the Multiple Employer Trusts (MET) to provide health insurance. This is working in North Carolina. A program recently enacted in Connecticut should also be examined. This plan includes some of the changes recommended earlier. Oregon, over the last few years, has moved to encourage small business to offer health insurance through tax incentives (2a. attached). This too should be studied.

As you can see, small business owners in New Jersey agree with many recommendations of the Governor's Commission on Health Care Costs.

However we part company on the "broad-based" employer tax and penalty for not providing health insurance. This employer tax, 1 percent of the first $14,000 earned, would for one year enable the state to eliminate the exisiting surcharge on hospital bills for uncompensated care.

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But what happens next year? There is not enough information on use of New Jersey's Uncompensated Care Trust Fund to indicate whether that amount is adequate now or in the future.

How can a new tax be justified without knowing what it will pay for, or if it is adequate to meet the future needs of the state's indigent. Once information is complied on the bad debt hospitals incur and the actual costs of caring for those less fortunate, a long term solution to the state's health care cost crisis is impossible.

As you can see, there are a number of different approaches to the health care/insurance cost crisis we now face. New Jersey's answer is a combination of approaches, many already successful in other states.

Whatever the legislative response to this serious problem, it should not serve to restrict the private sector with further mandates. The public and private sectors now have the opportunity to develop an innovative and comprehensive solution to the problem. NFIB/New Jersey looks forward to working with you to accomplish this.

Health Insurance cost control

HB 325

Florida House of Representatives - 1989

By Representatives Grindle, Deutsch, Locke, Gordon, Dantzler, Arnall, C. F. Jones, King, Juri, Irvine, Gutman, Kelly, Hargrett, Patchett, Sansom, Northam, Valdes

A bill to be entitled

An act relating to insurance; creating s. 627.6694, F.S.; providing for a basic policy of group insurance available to certain employers or groups of employers; providing definitions; providing policy coverage and benefits; providing for review and repeal; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.6694, Florida Statutes, is created to read:

627.6694 Small group health insurance policy.--

(1) A group of individuals may be insured under a basic policy of group health insurance issued to a small employer, or a group of small employers, and such policy may contain a package of benefits that does not include coverage for mandated benefits, provided that such basic policy complies with the other provisions of the Insurance Code.

(2) For the purposes of this section, the term:

(a) "Small group health insurance policy" means a policy issued to any one employer who employs less than 25 persons on a regular basis or to a group of small employers.

(b) "Small employer" means one employer who employs less than 25 persons on a regular basis.

(c) "Group of small employers" means two or more employers, each of whom employs less than 25 persons on a regular basis, who join together to purchase a small group health insurance policy.

CODING: Words stricken are deletions; words underlined are additions.

(d) "Mandated benefits" means those providers described or benefits required under ss. 627.419, 627.6573, 627.6574, 627.6575, 627.6577, 627.6579, 627.6612, 627.6615, 627.6616, 627.6617, 627.6618, 627.668, and 627.669.

(e) "Basic policy" means a group health insurance policy that is not required to contain any of the mandated benefits described in paragraph (d). Such basic policy may contain any one or more of said mandated benefits, but is not required to contain any such benefit.

(f) "Insurer" means any insurance company authorized to transact health insurance in this state.

(3) A group of small employers may join together for the purpose of purchasing a basic policy of group health insurance pursuant to the terms of this section. There shall be no restrictions regarding the membership in such a group of small employers based upon the location, profession, industry, or type of business conducted by any employer wishing to participate in such group of small employers.

(4) Any such basic policy issued hereunder may insure the spouse or dependent children with or without the employee of a member of a small group being insured.

Section 2. Each section which is added to chapter 627, Florida Statutes, by this act is repealed on October 1, 1992, and shall be reviewed by the Legislature pursuant to s. 11.61, Florida Statutes.

Section 3. This act shall take effect October 1, 1989.

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HOUSE SUMMARY

Provides for small group health insurance policies which may be issued to any one employer who employs less than 25 persons on a regular basis or to a group of small employers. Defines the term "group of small employers" to mean two or more employers, each of whom employs less than 25 persons on a regular basis, who join together to purchase a small group insurance policy. Provides exemption from certain mandated benefits in such policies. See bill for details.

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B-Engrossed
House Bill 2594

Ordered by the House June 16
Including House Amendments dated May 21 and June 16

Sponsored by COMMITTEE ON HUMAN RESOURCES (at the request of Joint Interim Committee on Health Care Cost Containment)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes Insurance Pool Governing Board [*and Insurance Pool Fund*]. Prescribes membership and duties of board.

Allows employers with 25 or fewer employes and who meet specified eligibility requirements to provide employes with catastrophic health insurance policy through pool. Requires employers who participate to pay portion of employe's premium. Allows limited tax credit for employer contributions to employe's premium. Phases out tax credit after fifth year of participation. **Limits participation to 10,000 eligible employes and family members at any time during biennium.**

Appropriates [$_____] **$1** from General Fund to Insurance Pool Governing Board for biennium.

A BILL FOR AN ACT

Relating to health insurance; and appropriating money.

Be It Enacted by the People of the State of Oregon:

SECTION 1. It is the intent of the Legislative Assembly by enactment of this Act to increase access to health insurance by developing a program employing preventative and primary care and then to minimize the medical care cost shifts caused by the providing of uncompensated care by hospitals.

SECTION 2. As used in this Act, unless the context requires otherwise:

(1) "Board" means the Insurance Pool Governing Board established under section 3 of this Act.

(2) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Insurance Commissioner, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

(3) "Class of employe" means an employe classed as either management or nonmanagement employe.

(4) "Eligible employe" means an employe of an employer who is employed by the employer for an average of at least 17.5 hours per week who elects to participate in one of the group benefit plans provided through board action, and sole proprietors, business partners, and limited partners. The term does not include individuals:

(a) Engaged as independent contractors.

(b) Whose periods of employment are on an intermittent or irregular basis.

(c) Who have been employed by the employer for fewer than 90 days.

(5) "Family member" means an eligible employe's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) "Health benefit plan" means a contract for group medical, surgical, hospital or any other

NOTE: Matter in bold face in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

remedial care recognized by state law and related services and supplies.

(7) "Premium" means the monthly or other periodic charge for a health benefit plan.

SECTION 3. (1) There is established an Insurance Pool Governing Board consisting of five voting members appointed by the Governor and as a nonvoting member, either the Insurance Commissioner or a designated representative thereof. Of the members appointed by the Governor, two shall be employers and at least two shall be knowledgeable about insurance but who are not officers or employes of a carrier and not consultants to a carrier or contractor.

(2) The term of office of each member is three years, but a voting member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

SECTION 4. Notwithstanding the term of office specified by section 3 of this Act, of the voting members first appointed to the Insurance Pool Governing Board:

(1) One shall serve for a term ending June 30, 1988.

(2) One shall serve for a term ending June 30, 1989.

(3) One shall serve for a term ending June 30, 1990.

(4) Two shall serve for terms ending June 30, 1991.

SECTION 5. (1) A member of the Insurance Pool Governing Board shall not be compensated but is entitled to reimbursement for expenses as provided in ORS 292.495 (2).

(2) The board shall select one of its voting members as chairperson and one of its voting or nonvoting members as vice-chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(3) A majority of the members of the board constitutes a quorum for the transaction of business.

(4) The board shall meet at least once every three months at a place, day and hour determined by the board. The board also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(5) In accordance with applicable provisions of ORS 183.310 to 183.550, the board may adopt rules necessary for the administration of the laws that the board is charged with administering.

SECTION 6. (1) In carrying out its duties under this Act, the Insurance Pool Governing Board shall:

(a) Enter into contracts for administration of this Act including collection of premiums and paying carriers.

(b) Enter into contracts with carriers or health care providers for health care insurance or services, including contracts where final payment may be reduced if usage is below a level fixed in the contract.

(c) Retain consultants and employ staff.

(d) Set premium rates for employes and employers.

(e) Perform other duties to provide low cost insurance plans of types likely to be purchased by eligible employers.

(2) Notwithstanding any other benefit plan contracted for and offered by the board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employes and employers.

(3) The board may approve more than one carrier for each type of plan contracted for and of-

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fered but the number of carriers shall be held to a number consistent with adequate service to eligible employes and family members.

(4) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employe may arrange coverage for family members of the employe.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employes and family members at an additional cost or premium.

(6) Transfer of enrollment from one plan to another shall be open to all eligible employes and family members under rules adopted by the board.

(7) If the board requests less service than is otherwise required by state law, a carrier is not required to offer such service.

SECTION 7. (1) The board shall have authority to employ whatever means are reasonably necessary to carry out the purposes of this Act. Such authority shall include but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract which in the board's judgment requires such action.

(2) The board by order may terminate the participation of any employer if for a period of three months the employer fails to perform any action required by this Act or by board rule.

SECTION 8. (1) The monthly contribution of each eligible employe for health benefit plan coverage shall be the total cost per month of the benefit coverage afforded under the plan or plans, for which the employe exercises the option, including the administrative expenses therefor less the portion thereof contributed by the employer. An employe may enroll in more than one option at a time so long as they do not offer overlapping services.

(2) The employer contribution shall be the amount necessary to pay the cost of the health benefit plan covering the employer's covered employes, as described in section 10 of this Act, and other plans selected by a covered employe for which the employer does not require the employe to pay, including the administrative expenses therefor. An employer is not required to enroll an employe who is already enrolled in a health benefit plan not offered by the Insurance Pool Governing Board.

(3) Payroll deductions for such costs as are not payable by the employer shall be made by the employer upon receipt of a signed authorization from the employe indicating an election to participate in the plan covering the employe or the employe's immediate family.

SECTION 9. (1) In order to be eligible to participate in the programs authorized by this Act, an employer shall:

(1) Employ no more than 25 employes.

(2) Have not contributed within the preceding two years to any insurance premium on behalf of an employe who is to be covered by the employer's contribution.

(3) Make a minimum contribution to be set by the board toward the premium incurred on behalf of a covered employe.

(4) An employer may elect to cover fewer than the total number of employes so long as its covered class includes all employes in the class.

SECTION 10. (1) Part I coverage shall focus on episodic acute care and recovery care for catastrophic illness or accident. The coverage applies to eligible covered employes only.

(2) The plan shall have a deductible and a high stop loss to insure that no employe is required to pay the costs of a major accident or illness, beyond the costs of the deductible and that Part I coverage can be obtained at a low enough cost to insure accessibility.

(3) Subject to subsection (4) of this section, employers shall pay the premium of Part I coverage

up to a maximum of $40 for each eligible covered employe per month.

(4) All covered eligible employes shall participate in and be covered by Part I coverage. An employer may require a minimum employe contribution of not to exceed 25 percent of the premium for Part I coverage described in this section.

SECTION 11. (1) Part II coverage shall consist of a variety of additional benefit packages which an employe may purchase. All packages shall contain incentives to encourage the employe to utilize intelligently services in a cost effective way and disincentives to discourage noncost effective use of services.

(2) At least one Part II package shall reduce the deductible of the Part I package, and provide for access to primary and preventive care. Additional benefit packages may include coverage for optical and dental care.

(3) Packages shall be available to extend coverage to the employe or the employe's family members.

(4) In general, Part II packages shall not provide benefits provided by Part I coverage. Employers may contribute toward the cost of Part II coverage, and may include the cost of Part II contributions when calculating tax credits available under this Act.

(5) The board may establish by rule that certain packages shall not be available to an employe who is not covered by a certain other package or packages.

SECTION 12. Section 13 of this Act is added to and made a part of ORS chapter 316.

SECTION 13. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a resident employer for amounts paid during the taxable year for purposes of this 1987 Act on behalf of an eligible employe as defined in section 2 of this 1987 Act to provide health insurance or care.

(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.

(3) As used in this section "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of section 2 of this 1987 Act.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this 1987 Act shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this 1987 Act.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the

same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 316.215, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 316.215.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to subsection (7) of section 15 of this 1987 Act, the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

SECTION 14. Section 15 of this Act is added to and made a part of ORS chapter 317.

SECTION 15. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of this 1987 Act on behalf of an eligible employe as defined in section 2 of this 1987 Act to provide care for a qualified individual.

(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this 1987 Act shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this 1987 Act.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the

Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in section 13 of this 1987 Act, based on that shareholder's pro rata share of the expenses described in this section.

SECTION 16. Section 17 of this Act is added to and made a part of ORS chapter 318.

SECTION 17. Section 15 of this 1987 Act, during its existence and as it may be amended, is incorporated into this chapter by reference and made a part hereof.

SECTION 18. Sections 13, 15 and 17 of this Act apply to tax years beginning on or after January 1, 1988. For all prior taxable years, the law in effect and applicable for those years shall continue to apply.

SECTION 19. There is appropriated to the Insurance Pool Governing Board, for the biennium ending June 30, 1989, out of the General Fund, the sum of $1 for the purpose of carrying out the provisions of this Act.

SECTION 20. For the biennium ending June 30, 1989, the Insurance Pool Governing Board shall not offer benefit plans to more than 10,000 eligible employes and family members at any time.

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State of New Jersey
DEVELOPMENTAL DISABILITIES COUNCIL

108-110 North Broad Street
CN 700
Trenton, New Jersey 08625
(609) 292-3745

November 14, 1990

Eleanor Seel, Committee Aide
Senate Institutions, Health &
Welfare Committee,
State House Annex, CN-068
Trenton, N.J. 08625-0068

Re: Comments Solicited on recommendations of the Governor's Commission on Health Care Costs.

Dear Ms. Seel;

The New Jersey Developmental Disabilities Planning Council is pleased to be able to comment on the recommendations of the Governor's Commission on Health Care Costs. It is of particular interest to the Council that issues related to health care and health care costs for individuals who have a developmental disability and their families be thoroughly addressed in any legislative or executive action on this topic.

It is essential that any plan to address health care costs not simply evolve into a short-lived band-aid or political handball. It is essential that root problems be addressed and not simply surface symptoms. Taken in total, the recommendations of the Commission appear to do this. **The Council is of the opinion that the full impact of all of the recommendations would be required to change New Jersey health care from a priviledge to a right.**

To that end the Council makes the attached comments regarding the report, and Health Costs issues related to the report's contents. [Reference is to pages in the 10/1/90 report received through the Governor's Office.]

ISSUE SUMMARY:

* CR-78: Any rewording regarding protection from exclusion due to a pre-existing condition must include reference to **"...regardless of disability unless the carrier can provide independent documentation of excessive health costs being related to the specific disability."** This is not dealt with in the Commission's report and should be included in any subsequent regulations.

* CR-67: The impact of group plans on people with developmental disabilities and their families is that:
a) they are unable to get covered,
b) when they can get coverage, they or their employer cannot afford the premiums.

* CR-36: The failure of the insurance industry to address the needs of people with disabilities has resulted in excessive episodic use of emergency rooms.

* CR-5: Any Health Care Planning Body must include representation from members of the disability community. This group is among the most-discriminated against in the failure of insurance companies to meet the public trust.

* NOTE: Any health carrier of group policies may be required to provide non-discrimination as a result of the Americans with Disabiulities Act of 1990. The Committee should include an estimate of the impact of the Act on its recommendations.

Thank you.

Dennis Rizzo, Planner
For the Council/ 11-14-90

COMMENTS ON REPORT OF
THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS
from
N.J. DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

* page 11 - CR-5: The Council wishes to insure that any State Health Planning Board established to review health services or policies in New Jersey will include representation from the disabled community.

As the State Planning Organization for developmentally disabled people, **the Developmental Disabilities Council requests to be added to the list of represented bodies on any State Health Planning Board.**

* page 21 - CR-32: The majority of people in New Jersey without health insurance are also those in greatest need of home health aides. The inability of the insurance industry to effectively and equitably address this need opens the door to an application for waiver of Medicaid regulations related to reimbursement of expenses incurred by a responsible relative. It also opens the door to regulatory prohibition of payments to those industry companies who gain from home health services but whose parent companies do not provide this as a covered reimbursement.

page 21 - CR-36:
page 22 - CR-38:
page 23 - CR-39: The Council's own study of existing health services for people with disabilities in New Jersey points to a serious abuse of emergency room services; use of emergency rooms for episodic care not only reduces the effectiveness of the emergency room itself, but provides care in the most expensive setting rather than the most appropriate.

Many people with disabilities use emergency rooms for episodic care because: a) it is the only form of health care service for which their carrier will insure them, b) it is the only resource due to cancellation or denial of insurance coverage, c) there is no practicioner willing to serve them through Medicai reimbursement.

Any effort to introduce more Community Health Centers must address the fact that people with disabilities are often excluded in the overall certificate of need process. **Any Community Health Center introduced henceforth must also meet the requirements of the Americans with Disabilities Act.** Certificates of need must reflect this.

page 31 - pp 4 & 6
page 33 - CR-68 (c)(iii): The Council's study has determined that the majority of people with significant, non-Medicaid, health coverage are made up of those who are employed or who are relatives of employed persons belonging to a group plan. Yet, many people find that upon attempting to use that policy coverage, services to their disabled relative are denied. In

almost every case, the person's disability is considered "...a pre-existing condition not covered under the policy and which makes the person uninsureable...."

The exhorbitant premiums charged to groups containing even as few as one disabled employee or relative has caused many an employer to drop either coverage or the employee. Most people dropped from group policies due to a "pre-existing condition" find re-insurance virtually impossible and private coverage unaffordable.

reference page 33, CR68-(c)(iii):

This points to a serious situation which is addressed only partially in the commission's report. **Any regulation or legislation which attempts to address health care must insure that an individual or family member can obtain insurance coverage at the same rates and levels of coverage as the average member of the employee group or policy group, and that any insurance carrier cannot deny coverage to any individual for a pre-existing condition or as a result of an existing or subsequent disability.**

page 36 - CR-78: The Council is of the opinion that any change in wording regarding coverage exclusions must read: **"Regardless of Disability unless the insurer can provide independently derived documentation of unusually high or incidence of health costs [not rehabilitation costs] in persons having the disability.**

Document 5W: The Council also recommends further study of the results of the Ohio Insurance Task Force Study, and supports serious consideration of the option of implementing the Canadian Single Payer Format and obtaining all necessary federal waivers to do so.

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I have come to speak against mandatory medicare assignment.

I firstly would like to point out that seniors with medicare can not be charged more than the maximum that the Federal government allows under the MAAC.

In all cases the MAAC is no higher and in most cases this fee is significantly lower than the fee charges to non-seniors.

Thus, we already have in place a system whereby senior's lower fees are being subsidized by higher fees of non-seniors.

In effect, this means that seniors without regard to their financial situation are being subsidized by non seniors without regard to their financial circumstances.

My patients have already noticed this discrepancy in fees. I have already received multiple complaints about this discrepancy. Some patients with limited incomes have complained quite vociferously that they should not be expected to subsidize wealthy seniors.

Making mandatory medicare assignment will be responsible for greater cost shifting of fees without regard to financial ability from seniors to non seniors.

I would like to point out that seniors access to health care will be restricted by mandatory medicare assignment. The seniors who will suffer most are those who are most frail and defenseless. Those of us who still make house calls on seniors and those of us who do consults in nursing homes may no longer be able to provide this care if mandatory assignment becomes a reality. I have already heard colleagues discuss their desire to attract non seniors.

More talks are being held on how to provide less care to seniors. Less time to talk to seniors during their visits is the plan for the future. Only one problem on a visit is what seniors will be told. Seniors are already being told that many physicians will not draw blood and they must make a separate trip to a lab. This is because the federal government has placed mandatory medicare assignment for blood drawing.

Thus, mandatory assignment will be responsible for cost shifting from old to young without regard to financial need. It will also limit access to health care to the seniors.

Instead of physicians deciding what's best for their patients it will be the federal bureaucrat who will tell the physician what tune he and his patient must dance to.

With all this I can not understand the demand for this legislation when seniors who have medicaid are already on mandatory assignment by federal law. Even before this law, over 70% of all medicare claims were accepted for assignment.

Voluntary programs throughout the state exist by which physicians accept assignment on those selected as in need by joint committees of seniors and physicians.

The disruption and problems caused by mandatory assignment cannot be justified by the small change in cases accepted for assignment. Both seniors and non-seniors would lose by mandatory assignment.

Jon Wininger

HPMSNJ
HEALTHCARE PLANNING AND MARKETING SOCIETY OF NEW JERSEY
SEVEN HUNDRED SIXTY ALEXANDER ROAD • CN 1 • PRINCETON, N.J. 08540 (609) 275-4000

November 26, 1990

The Senate Health & Institutions Committee
c/o Eleanor Seel
Office of Legislative Services
State House Annex
CN068
Trenton, New Jersey 08625

Re: Report of the Governor's
Commission on Health Care

Members of the Senate Health & Institutions Committee:

I am pleased to submit the attached testimony regarding the recommendations of the Governor's Commission on Health Care on behalf of the Healthcare Planning & Marketing Society of New Jersey. HPMSNJ is a professional organization comprising planners and marketers from health care organizations throughout New Jersey. The enclosed position paper was endorsed by the HPMSNJ Board of Directors at its November 9, 1990 meeting.

Overall, the Society believes that change in the current health care regulatory system is warranted and we support the diligent work of the Commission members in formulating these recommendations. We view the Commission's Report as addressing "macro" level changes which are long overdue; however, as professionals who have daily interaction with the State health planning system and Certificate of Need process, we have substantial concerns regarding the "micro" level impact legislative and regulatory changes could have on health care providers. We hope our comments will caution the Committee as to areas where further technical consideration is needed prior to change.

The testimony of HPMSNJ is limited to the Commission Report Section titled, "Regulatory Reform" according to the interest and professional expertise of the members of the Society. These comments are numbered to correspond with the Commission recommendations, CR3-CR17. Should you require additional information, all inquiries should be addressed to me at the

following address:

Rebecca Wolff, Director of Planning
Morristown Memorial Hospital
100 Madison Avenue
P. O. Box 1956
Morristown, NJ 07962-1956

1-201-285-4385

Thank you for the opportunity to provide this testimony.

Sincerely,

Rebecca Wolff

Rebecca Wolff
President, HPMSNJ

enclosure

cc: Louis Scibetta, President, NJHA
Harvey Holzberg, Chairman, NJHA Council on Planning
Tom Foley, Chairman, Health Care Administration Board
Ralph Dean, Chairman, Statewide Health Coordinating Council
Brenda Bacon, Office of the Governor
Frances Dunstun, MD, Commissioner of Health

Healthcare Planning and Marketing Society of New Jersey
Testimony Pertaining to the Report of the Governor's Commission On Health Care
Section on Regulatory Reform
Endorsed by HPMSNJ Board: November 9, 1990

Planning Reform

CR3. State Health Plan

- We believe that it is unrealistic to have a State Health Plan which identifies all health care needs of New Jersey residents; health care is changing rapidly and the State is geographically and demographically diverse. Therefore it is very unlikely that one set of statewide criteria can apply equally well to all areas of the state. There must be a provision to respond to area-specific needs which are not identified in the Plan.

- To meet the needs of New Jersey residents, the State Health Plan must remain flexible and should include waiver criteria under which a Certificate of Need could be submitted. The waiver criteria should be service specific and consider such factors as utilization, access and other pertinent issues. With a well developed State Health Plan, relatively few Certificates of Need will need to be granted under a waiver provision.

- The intent of this recommendation appears to be the development of a State Health Plan as the driving force for centralized health planning and submission of Certificate of Need applications. As such, it is essential that health care provider input be incorporated into the development and ongoing modification of the State Health Plan.

- We are concerned that the State Plan reflect fully the complex and dynamic nature of the delivery of health services. This concern is expressed in light of the severe limitations of State Health Department budgets at a time when demands on it are being increased.

CR4. Local Advisory Boards

- There must be a provision for local input which includes the opportunity for affected parties to make public comment.

- Historically, local health planning models have not provided sufficient local input into the identification of local needs and development of

CR4. Local Advisory Boards (Continued)

programs and policies to meet those needs, and into the development of the State Plan.

- If constituted, these local bodies should be separately constituted 501 (C) (3) corporations who are allowed to seek sources of funds in addition to State allocated funding.

- As autonomous entities the local bodies should be free to determine the composition of their boards so long as these boards are 1) representative of the geographic area and 2) have a consumer majority.

- We note that the Commission's report provides for only limited local input into the Certificate of Need review. For example, how can the LAB's review and make independent assessments of Certificates of Need if the analysis of need is conducted by State staff and no exceptions are allowed.

CR5. State Health Planning Board

- In order to allow for sufficient provider and consumer representation, there needs to be a further consideration of the number of seats allocated to government officials. There is concern that the proposed structure would limit provider input significantly.

CR6. Role of Health Care Administration Board

- The State Health Plan, as other issues reviewed by HCAB, must be subject to a public comment period.

- The Board should be required to respond to all comments it receives in a public meeting.

<u>Certificate of Need Reform</u>

CR7. State Health Plan

- As stated above, waivers to the State Health Plan should be permitted. Providers should be allowed to submit Certificates of Need for services that are not identified in the State Health Plan as "needed services" without the requirement that the State Health Plan be revised prior to their review. There should be a mechanism in place to concurrently grant a waiver to the State Health Plan for the specific situation and review these projects. These waivers

and proposals must be handled on a case by case basis.

- Local health planning, if it continues to be funded, should provide input into developing the State Health Plan.

CR8. Role of the Commissioner

- The roles of the Commissioner and HCAB in the final decisions to grant or not grant CN's needs to be clarified.

CR9. Appeal Rights

- We support the affirmation of the applicant's appeal rights and believe it is essential that applicants who are denied a Certificate of Need have the opportunity to appeal the Commissioner's decision under the current process.

Certificate of Need Application

CR10. Definition of Health Care Facility

- In support of this recommendation, it is appropriate that Certificate of Need requirements be determined by the type of service as opposed to by facility ownership.

CR11. Certificate of Need Thresholds

- It is appropriate that Certificate of Need thresholds be raised; $1.0 million is probably appropriate for major moveable equipment, however, the construction threshold should be higher ($1.5 million as recommended in the draft CN regulations).

CR12. Annual Cap On Capital Projects

- Limiting capital dollars may be necessary, however, an annual cap may lead to inequitable considerations of competing projects.

- It is critically important, if there are to be caps, that there be an equitable process for allocating capital among competing projects. This process should specifically address both the need for some facilities to expand in response to population growth and others to renovate and modernize without expanding, in order to remain competitive.

- We are greatly concerned that caps may unfairly

postpone needed maintenance to the State's health system infrastructure, increase future costs because of deferred construction/renovation, and may result in New Jersey facilities being less than competitive with New York and Pennsylvania facilities.

- Provision should be made for hospitals to build equity as an alternative to debt financing.

CR13. DOH To Review and Categorize Providers by Plant Conditions

- Health care providers cannot be categorized based on facility age alone. Also to be considered in capital prioritization are types services provided, populations served, potential for growth in demand, and institutional mission.

- Providers must have input into developing the criteria which will serve as the basis of how projects are to be prioritized.

- Prioritization must be reviewed on a per project basis.

CR14. Elimination of 1991 Capital Batches

- We feel <u>any</u> moratorium could have serious negative consequences for the State's health care industry. The experience in New Jersey suggests that any moratorium is likely to last longer than one year.

CR15. DOH Given Authority to Decertify Paper Beds

- We believe adequate regulatory authority already exists for this purpose.

CR16. CN Period of Implementation

- Varying the period of time for which CN is valid according to the type of project is a positive change.

- Terminating CN's not implemented within the regulatory time frame should not be permitted without the applicant being given the opportunity to request an extension as significant resources may already have been invested.

- It is unclear from these recommendations, as to what constitutes "implementation" of CN.

CR17. Physicians Prohibited From Referring To Service In Which He/She Has An Interest

- We see this as seriously counterproductive. It would inhibit, if not preclude, the development of joint ventures which reduce demands for hospital borrowing, spread risk, and provide a means to cost effectively and quickly respond to emerging needs. We believe that full disclosure of interests and providing information on alternative services should be sufficient.

This concludes the comments from HPMSNJ relative to the Commission's Report, Section on Regulatory Reform.

THE NEW JERSEY DIETETIC ASSOCIATION, INC.
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November 1990

On behalf of the 2,000 members of the New Jersey Dietetic Association I would like to thank you for the extended time deadline for written comments on the report submitted by the Governor's Commission on Health Care Costs entitled "Cost, Accessibility, Responsibility, Efficiency for New Jersey."

The members of the New Jersey Dietetic Association are dedicated to promoting the optimal health and nutritional status of New Jersey Residents in their various roles as dietetic practitioners in hospitals, long term care facilities, community/public health organizations, business and industry, schools, private practice, research, and the media.

We applaud your efforts in addressing the crisis of health care costs, with emphasis on cost containment and continued access to appropriate health care. We are concerned about the role and accessibility of nutrition in health care, and the role that dietary factors can play in the area of cost containment, especially in managed health care.

The 1988 "Surgeon General's Report on Nutrition and Health" found that for the 2 out of 3 Americans who neither smoke nor drink eating patterns may shape their long-term health prospects more than any other personal choice. We know that dietary factors are associated with 5 of the 10 leading causes of death in the United States: coronary heart disease, some types of cancer, stroke, non insulin-dependent diabetes mellitus, and atherosclerosis. In "Healthy People 2,000," released by Secretary Louis W. Sullivan on September 6, 1990, we see thirteen major health status and risk reduction nutrition objectives in a national initiative to improve the health of all Americans significantly over the next 10 years.

We believe strongly that access to high quality nutrition services as a part of a managed health care system for all will enhance wellness and will delay and minimize the onset of many of the chronic diseases developed by New Jersey residents. Nutrition on the front end of health care will in many cases reduce the need for expensive medications and hospital/specialized care later on. This has been clearly demonstrated in programs such as WIC where every $ spent on program service has saved #3 in future health care costs.

We would like to offer the following specific comments on the Commission Recommendations for Medicaid Reform and Expansion:

1) CR18. Garden State Health Plan Enrollment of Medicaid clients should be expanded using every means possible.

We agree with the concept of high quality accessible care, moderate program costs, and increased provider participation. We believe that reimbursement for nutrition services in an excellent option for achieving this recommendation.

2) CR21. Medicaid will expand the use of alternative health care delivery sites and health professionals.

We support the establishment of alternative sites of health care delivery and the expansion of home health care, and see qualified dietetic practitioners in these settings as major players in delivering high-quality care at reasonable costs.

3) CR27. A "HealthStart Plus" program should be created using a two-tiered insurance approval to insure comprehensive medical and support services to pregnant women up to 300 percent of the poverty level.

We strongly support this program and commend the Commission for including nutrition counseling for poor pregnant women as a means to improving pregnancy outcome. This approach has proven very successful in the current HealthStart Program as well as the WIC Program.

4) CR33. The state should explore a federal waiver for the inclusion of wellness benefits in the Medicaid program.

We support this concept and urge that nutrition counseling and services be included in these wellness benefits, especially in relationship to weight management and control of dietary factors related to the chronic diseases i.e., fat, cholesterol, fiber, alcohol intake, etc.

Under the Commission Recommendations for Community Based Services we have the following comments:

5) CR37. Greater emphasis on the use of school-based health clinics should be made as a means of improving early disease prevention and health promotion for all children starting at the elementary school level.

We recommend that nutrition services be included in the school based health clinics; that nutrition be included in the expanded curriculum; and that qualified dietetic practitioners work closely with the health education department and coaching staff. In a fitness study done on a group of predominantly tenth and eleventh graders at an urban high school Health and Fitness Fair in Camden City in December of 1988, it was found that there was a need for intensive efforts to increase the level of awareness about the importance of regular exercise and healthy

eating habits. Significant numbers of students in the sample of 300 studied required intervention and follow-up for obesity, elevated cholesterol levels, and poor cardiovascular fitness - at ages well before adulthood.

Under the Commission Recommendations for Subsidized Programs to Improve Access to Insurance we have the following comments:

6) CR66. Managed care insurance plans should be encouraged over traditional fee-for-service indemnity plans.

We support this recommendation and urge the inclusion of nutrition counseling and services by qualified dietetic practitioners in managed care plans as a major way to judiciously spend resources to keep people healthy, with the economic benefit of reducing the cost of future "sick care."

7) CR59. Physician Assistants should be considered for licensure in New Jersey.

We support the use of licensed physician assistants. Physician assistants, like dietitians, can provide needed services at reasonable costs.

8) CR60. Efforts to address the nursing shortage should be continued.

Shortages of health professionals are anticipated to escalate throughout this decade. In 1987 the New Jersey Department of Labor estimated the changes in allied health from 1985-1995. In 1989, the annual occupational supply and demand report estimated the growth of allied health and nursing from 1986-2000. Both reports illustrate that efforts to address all allied health shortages should be included. Summary charts are attached.

9) CR65. Legislative and educational initiatives should be pursued to encourage people to develop living wills.

We support the need for clear directives by individuals on their wishes at both the terminal stages of life and for those in persistent vegetative states. Feeding is often a crucial issue which involves the dietitian with the medical team.

In allocating the dollars raised for uncompensated care we support the seven major goals identified by the Commission and strongly recommend the inclusion of a nutrition component in Goals (2), (3), and (6).

In addition to the specific comments and recommendations above, we would like to encourage the expansion of nutrition services and resources within the New Jersey Department of Health, with special emphasis on the AIDS Program, Adolescents, Health Promotion and Disease Prvention, and in the area of Minority Health.

We are available to answer any questions regarding our comments, or to provide additional data and background materials to support our recommendations. We would also welcome the opportunity to have nutrition representation on future health care planning commissions or work groups appointed by the Governor or Health Commissioner in New Jersey.

NJ HEALTH MANPOWER NEEDS
1985 TO 1995

PROFESSION	POSITIONS	% INCREASE
Dental Assisting	2,150	+39%
Dental Hygiene	1,050	+39%
EMT-Paramedic	450	+24%
Dietetics	350	+29%
Medical Technology	1,450	+25%
Respiratory Therapy	600	+40%
Physical Therapy	850	+41%
Radiography	1,150	+36%
Cardiovascular	950	+43%
Nursing	22,600	+49%
*Non Health Fields		+16%

Source: NJ Dept Labor, 1987

XHLI

GROWTH ESTIMATES OF ALLIED HEALTH AND NURSING 1986-2000

Career	Employment 1986	Employment 2000	Numerical Increase	% Increase
Dental Assisting	5,100	7,400	2,300	45.1
Dental Hygiene	2,200	3,500	1,300	59.1
EMT-Paramedic	2,700	3,400	700	25.9
Medical Technology	12,500	19,600	7,100	56.8
Med. Lab Tech.	7,300	9,800	2,500	34.2
Radiography	4,600	7,500	2,900	63.0
Registered Nurse	52,200	80,600	28,400	54.4
Respiratory Therapy	1,400	2,000	600	42.9
Surgical Technology	500	700	200	40.0

(Source: Annual Occupational Supply and Demand Report of the New Jersey Occupational Information Coordinating Committee, 1989)