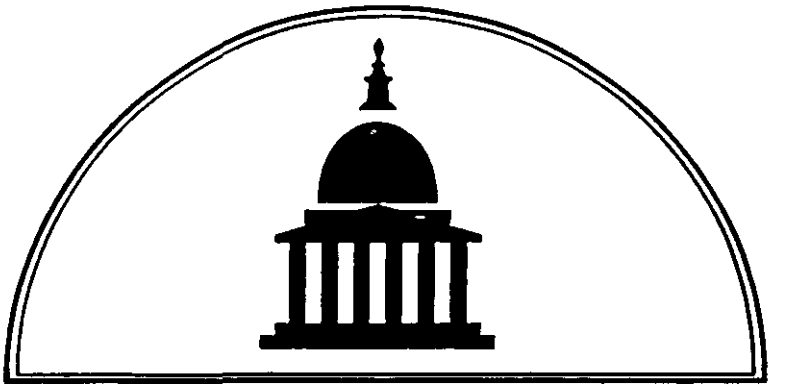

NEW JERSEY'S HEALTH CARE REFORM LEGISLATION: SUMMARY AND COMMENTS

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NEW JERSEY'S HEALTH CARE REFORM LEGISLATION: A SUMMARY AND COMMENTS

An issue brief on

"The Health Care Reform Act of 1992, and New Jersey's Continuing Commitment to Universal Access"

prepared by
Professor Susan Walmsley-Ault

for discussion at the February 2, 1993 Capitol Forum

BACKGROUND

Since 1978 the hospital industry in New Jersey has been among the most closely regulated in the nation. Legislation and regulation have defined the industry's reimbursement methodology, reimbursement rates, and controlled the establishment and expansion of health care facilities, programs and technologies, New Jersey's regulated health care system was designed to control costs while assuring access and maintaining quality and, to a large extent, it did succeed in achieving these goals. Cost increases were maintained below regional averages, and access to acute health care services for the poor and uninsured was greatly improved.

In recent years, however, the system has been placed under increasing strain by the mounting burden of uncompensated care provided by the State's hospitals. New Jersey's hospital payment system required that private and third-party payers accept responsibility for the cost of charity care. Initially this was accomplished by cost-shifting increases in the rates charged by individual hospitals. Then, in 1987, the New Jersey Uncompensated Care Trust Fund was established to assure equitable reimbursement for uncompensated care to New Jersey's hospitals. A surcharge on hospital bills was required to support the Fund. This surcharge has more than doubled in the last five years, accounting for 19.1% of every hospital bill generated in 1992.

The situation became a crisis when a self-insured union challenged the state surcharge in federal court. The union claimed that the surcharge requirement violated the Employee Retirement Income Security Act which precludes state infringement upon employee benefits. In his decision, United States District Court Judge Alfred Wolin supported the union's position and declared that New Jersey's health care regulatory and financing systems, as described in Chapter 83, violated federal law and were thus unenforceable.

This decision, combined with the pre-existing pressures of rapidly increasing charity care costs, payer and consumer dissatisfaction with the surcharge and DRG (Diagnosis Related Group) systems and growing national interest in health care financing systems which use rather than preclude competition, led to the development of the Health Reform Act of 1992 and the two health insurance reform laws which were enacted along with it.

THE HEALTH CARE REFORM ACT OF 1992

The purpose of this legislation is "...to ensure access to and provision of high-quality and cost-effective hospital care to New Jersey's citizens". In order to achieve this goal the legislation provides a "broad-based funding mechanism" for charity care and other uncompensated care, decreases regulation of hospital reimbursement and diminishes regulation of hospital program and facility planning. Decreases in regulation are included in a stated effort to allow market forces to create cost-containment motivation in the health care industry.

All of New Jersey's citizens are assured access to necessary hospital services under the provision of this law. In order to provide the financial support necessary for hospitals to carry out this state-mandated obligation, the Act establishes the Health Care Subsidy Fund, which is to be funded by employer and employee contributions transferred from the State's Unemployment Compensation Fund. The Health Care Subsidy Fund will contain four separate accounts:

- One account to provide charity care subsidy payments to "disproportionate share" hospitals.*
- A second account to fund subsidy payments for "other uncompensated care", largely Medicare, to disproportionate share hospitals.
- A third account to fund the New Jersey Shield Program.
- A fourth account to provide support for hospital and other health care initiatives, and to establish a bond reserve fund in cooperation with the Health Care Facilities Financing Authority.

The third account is to be funded by an assessment of .53% of all hospital approved revenue, not to exceed $40,000,000.

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* Disproportionate Share Hospitals are the 80% of NJ's hospitals with the greatest % of uncompensated care cost in relation to total approved hospital costs.

The Fund is to be administered by a newly established, 11 member independent commission, the New Jersey Essential Health Services Commission Under the provisions of the Act the Commission is charged with the responsibility to:

- develop and implement systems for the dispersal of monies from the Fund accounts
- develop a database regarding charity care utilization and users
- monitor hospital rates and contracting practices
- review and assess the adequacy of Medicare hospital rates and Medicaid provider rates
- assess hospital charges in New Jersey relative to those in other states
- study managed care options for charity care services
- encourage centralized data storage and transmittal systems
- establish the New Jersey Shield Program

The New Jersey Shield Program which is to be implemented by the Commission is intended to provide subsidies for health benefits coverage of working people and the temporarily unemployed when health care services are delivered in "disproportionate share" hospitals and by other community-based health care providers. Preventative and primary care, as well as acute care, are to be covered. This program will be funded from an account in the Health Care Subsidy Fund. Funding will begin in 1994 with $50,000,000, increasing in annual steps to $200,000,000 in 1997 "...and each year afterward".

In addition to establishing the Essential Health Care Services Commission, the Health Care Subsidy Fund and the New Jersey Shield Program, the Health Care Reform Act also rescinds many of the regulatory requirements which have been placed upon the hospital industry. Specifically, the Act eliminates the Diagnosis Related Group (DRG) reimbursement methodology and calls for a largely deregulated reimbursement system by 1994. The transition to this unregulated system is provided in 1993 by the introduction of an interim reimbursement method to be administered by the Hospital Rate Setting Commission.

For 1993 the Rate Setting Commission will establish a revenue cap for each hospital, which establishes the maximum amount the hospital may collect for the year from all payers, with the exclusion of payments received from the Health Care Subsidy Fund. This cap amount is to include components for bad debt, the hospital's share of outstanding reconciliation amounts, and the specific amount agree to by the hospital pursuant to the 1990 voluntary settlement program. In

no instance, however, will the 1993 cap be permitted to exceed the hospital's preliminary cost base for 1992. The State also releases itself from responsibility for any deficiencies in revenue collection which may occur during 1993.

Hospitals which enter into discounting arrangements with third parties may only do so in 1993 if the negotiated discount reflects cost-savings rather than cost-shifting from one payer to another. In subsequent years, oversight of hospital reimbursement contracting is transferred to the Essential Health Care Services Commission.

In addition to these changes in reimbursement regulation the Health Care Reform Act also significantly narrows the scope of the Certificates of Need program. Certificates of Need will no longer be required when the expenditure represents less than 5% of the operating revenue of the facility: exceptions to the new threshold are the initiation of a new service (if covered by state planning regulations) and initiation or expansion of physical facilities. Certain types of facilities will be exempt from Certificates of Need rules altogether: community-based primary care centers, outpatient drug and alcohol services, non-bed related mental health services, mandatory renovations of facilities, mandatory equipment replacement, chronic renal dialysis facilities, and changes in residential health care facility services.

CHAPTER 161, THE INDIVIDUAL HEALTH INSURANCE REFORM ACT

The purpose of Chapter 161 is to require the provision of individual health benefits coverage by all carriers doing business in New Jersey. The Act attempts to accomplish this by establishing the New Jersey Individual Health Coverage Program. Under the terms of this legislation all health benefits carriers become members of the newly established Program. Each member of the Program is required to do the following as conditions of doing business in New Jersey:

- Provide individual policies on a community rated basis.* Some rate differentials will be allowed for policies issued before the Act but, effective July 1,1995 all new and renewed policies must be community rated.
- Provide open enrollment periods.
- Allow renewal at the option of the policyholder unless there has been nonpayment of premium, fraud, misrepresentation, termination of eligibility or cancellation of the plan itself by the Board or the carrier.

* Under community rating, rates are based on the pooled risk represented by the entire group not upon individual health experience.

- Utilize standard contracts and policy forms established by the Board of the Individual Health Coverage Program.
- Provide benefit levels established by the Board of the Individual Health Coverage Program.
- Require no more than a twelve month limitation on coverage for pre-existing conditions.
- File rates, and anticipated changed in rates, with the Board prior to their effective dates.
- Offer five standard health plans established by the Board which include a basis policy, a managed care option and three additional policies of increasing actuarial value. Other plans may be offered if approved by the Board.
- Impose deductibles of no more than $250 for individuals and $500 for families; copayments of no more than $500 for both individuals and families, unless otherwise approved by the Board.

The Board of the newly established Program is a nine member body which is charged with a number of responsibilities, among which are the following:

- Development, within ninety days of appointment, of a plan of operation which establishes procedures for management and accounting of monies and assets, reporting to the Commissioner of Insurance, collecting member assessments, approving specific individual plans and imposing penalties for violations.
- Assessment of members for their proportionate share of Program losses, either retrospectively or prospectively.
- Establishment of rules, conditions and procedures for the sharing of Program losses and administrative expense.
- Review of rate applications and form filings submitted by carriers.
- Development of the five standard health benefit plans.
- Establishment of minimum performance standards for members and audit of that performance, specifically if the member is receiving program support.

In order to cover losses which may be experienced by some Program members in providing individual coverage the Board will implement an assessment system among the membership. Coverable losses will be defined as the amount by which claims paid and reasonable administrative expenses exceed the net earned premium and investment income thereon. All

members who do not provide individual coverage, or who do not provide the quantity required by the Board, shall pay an assessment to cover the Program's aggregate losses. Members which are deemed financially impaired by the Commissioner of Insurance or the courts may receive a deferral of their assessments. Deferred amounts may be levied against other members paying assessments. Members who fail to pay their assessments will forfeit their authorization to do business in New Jersey.

Each member's assessment will be based upon their percentage of total net premium of the Program. That percentage will be applied to total Program losses to determine the amount of the individual assessment. An exception to this method for determining assessments is that no single member will be assessed more than 35% of total Program losses. If this stipulation results in non-coverage of total losses, all assessed members with assessments of less than 35% of total losses, will share in the remaining assessment burden.

CHAPTER 162, SMALL GROUP INSURANCE REFORM

Chapter 162 is intended to make small group insurance more affordable and available; and to assure the financial stability of carriers which provide such coverage. The Chapter attempts to achieve these goals by establishing the New Jersey Small Employer Health Excess Reinsurance Program. All carriers which offer small group insurance in the state are required to participate in this program, effective January 1, 1994. An eleven member governing Board, selected by the membership, is charged with the responsibility for developing and enforcing the conditions of carrier participation in the Program. The Board is also responsible for the administration of a reinsurance program for the membership.

Each of these Board obligations is outlined in detail in the legislation. Among the conditions of membership which the Board shall enforce are the following:

- Acceptance of a three year transition to full community rating for small group plans. During the transition's first two years, 1994 and 1995, rates for holders of identical policies may vary by no more than 300%. During 1996, the last transition year, rates for holders of identical policies may vary by no more than 200%. Effective January 1, 1997 all small group policies will be fully community rated.

- Effective January 1, 1995, willingness to issue dividends or credits to policyholders if premiums received exceed payments to policyholders by more than 25%. As of that date, requests for premium increases will be denied by the Commissioner of Insurance if such increases would result in total premiums exceeding total payments by more than 25%.

- Utilization of standard claim forms, policy forms and reporting formats as

determined by the Board.

- Elimination of health status and health history limitations on coverage, except that late enrollees or members of groups of only two to five members may have a 180 day period of benefit limitation for pre-existing conditions.

- Provision of the five standard health plans to be developed by the Program as well as any riders which the Program approves. These five plans will include a basic plan, a managed care option, and three additional plans of increasing value.

- Extension of coverage in all policies to terminated employees for a period not to exceed twelve months. Coverage can be canceled only if the employee was terminated with cause, joins another plan, does not make premium payments, becomes Medicare eligible, or the employer ceases to offer health benefits to any of his employees.

- Imposition of deductibles may not exceed $250 for individuals and $500 for families; co-payments may not exceed $500 for individuals or families.

- Renewal of policies at the policyholder's option unless there has been fraud, misrepresentation, nonpayment of premiums, inadequate numbers of enrollees or noncompliance with employment contribution requirements.

- Agreement to annually file schedules of premiums, rating plans, actuarial plans and methods used to establish premium rates with the Commissioner of Insurance.

The Board of the Program shall also be responsible for developing and implementing a reinsurance program for its membership. All small group carriers will be given the opportunity to elect to be risk-assuming or reinsuring carriers. This choice, once approved by the Commissioner of Insurance, will determine whether or not the carrier will receive reimbursement if it incurs losses in its small group business. If a carrier elects to be risk-assuming it will not be reimbursed for any of its losses but it will also bear greatly reduced responsibility for the losses of other carriers. Reinsuring carriers, on the other hand, will be reimbursed for 80% of all losses after policyholder payments exceed premium by 20%. This reimbursement will be funded by an assessment of up to 4% of total premiums of all reinsuring carriers. If losses exceed this amount risk-assuming carriers and reinsuring carriers will all be assessed up to 1% of all health care premiums received in the last calendar year.

The Board will carry out its responsibility for the reinsurance program with the assistance of an administrative carrier, selected for expertise in the field, which will advise the Board on specific reinsurance issues and carry out administrative tasks at the Board's request.

Carriers not participating in the New Jersey Small Employers Health Excess Reinsurance Program will not be eligible to offer small group plans in New Jersey effective January 1, 1994.

Such carriers will not be allowed to re-enter the small group market for five years.

CONCLUDING COMMENTS

These three pieces of legislation were the result of a political process which required compromise, concern for the interests of various constituencies, and consideration of ultimate enforceability. The legislation also deals with issues which are inherently complex, and have many vocal and persuasive stakeholders. These factors have resulted in laws which are complicated in content and are likely to produce a variety of outcomes including:

- Difficulty in implementing legislated programs due to inadequate articulation of intent. Confusion and concern among insurers, health care providers and consumers exists. The measures presented in the new laws represent a dramatic departure from previous state policies. It can be anticipated, based upon theory and experience, that constituencies which are, or perceive themselves to be, placed at risk due to these changes will form defensive coalitions and attempt to alter, circumvent or use the new laws to their advantage.

  The new programs which have been introduced have the objective of assuring universal access to health care services. The ability to actually produce this effect may be limited by the extent to which certain concepts contained in the legislation are not fully developed. The New Jersey Shield Program, for instance, is a major policy initiative in the direction of universal coverage but it's services, eligibility standards, funding and administrative structure are presented in only skeletal fashion, filling half a page of forty-two page document. The relationship between the proposed Shield Program and the Health Care Subsidy Fund also needs to be more fully explained, particularly clarification of the seemingly overlapping eligibility criteria for the two programs.

- The possibility of decreased access to health care service for certain citizens exists. The newly deregulated hospital reimbursement system provides no safeguards for middle class insured citizens against greatly increased out-of-pocket expense for hospital services. As long as a hospital remains within the 1993 revenue cap, it can charge what it wishes for individual services. Beginning in 1994, there will be no restraint on specific charges. For the middle and working class family such a situation can easily lead to hundreds if not thousands of uncovered charges for each hospitalization.

  In addition to the possibility of denying the right to health care due to out-of-pocket expenses, there is also the danger of eliminating certain services in some communities. Hospitals will undoubtedly begin to find it necessary to shed unprofitable services in this new unregulated environment. Hospital services which do not produce adequate profit may be eliminated with no certainty that consumers will have geographic or financial access to appropriate alternatives. The least vocal consumer constituents, i.e., the poor, the elderly, the mentally disabled, and our children may be most affected by these measures.

- There is potential for widely varying impact of rate deregulation upon urban hospitals and

their suburban counterparts. Since urban hospitals provide the majority of the poverty care offered in the state, their condition must be closely monitored during this transition period and a contingency plan developed to assure their continuing stability and viability.

- Continued shortfalls in Medicare and Medicaid reimbursement can be anticipated. The shortfalls being experienced in the Medicare and Medicaid programs received little attention in the health reform legislation. Cost shifting cannot be further decreased or eliminated until satisfactory mechanisms are developed to decrease the costs of these programs and fund any unavoidable shortfall.

- Only limited success in broadened participation in small group health insurance can be expected. Similar pooled programs have been enacted and work well in other states but only with the commitment of all employers to universal coverage of employee groups. This legislation, in not addressing that central element of successful pooled risk programs, decreases the likelihood of program success and fails to meet the needs of working men and women for health care benefits.

The belief that classical market forces can operate equitably in the health care industry is open to question. Development of true market conditions requires that the consumer (purchaser) of services has a knowledge of market alternatives and the ability to exercise personal choice among those alternatives. Neither of these conditions exist for the consumers of health care services. Usually it is physicians and insurers who actually make the purchase decision. Often the result is a set of choices which meet the needs of the intermediaries, not the consumers. If the State intends to meet the needs of all its citizens, it must develop measures to prevent uncontrolled service elimination and unlimited out-of-pocket expenses.

With all of the caveats just mentioned it is still true that New Jersey, through the health care reform legislation, continues it's commitment to assure access to health care services for all of its citizens. The fact that New Jersey did not back away from this commitment in a moment of crisis should cause us to be proud.