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

before

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

"To examine problems relating to access to health care in the State"

July 18, 1990
Schering-Plough Corporation
Auditorium
Kenilworth, New Jersey

MEMBERS OF COMMISSION PRESENT:

Assemblyman James E. McGreevey, Chairman
Assemblyman Jackie R. Mattison
Assemblyman Nicholas R. Felice

ALSO PRESENT:

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

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Hearing Recorded and Transcribed by
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New Jersey State Legislature
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625-0068
(609) 292-1646

NOTICE OF A PUBLIC HEARING

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

Wednesday, July 18, 1990, 10:00 A.M.
Schering-Plough Corporation
Auditorium
2000 Galloping Hill Road
Kenilworth, New Jersey

The Assembly Health Care Policy Study Commission will hold a public hearing on Wednesday, July 18, 1990, beginning at 10:00 A.M., in the auditorium at Schering-Plough Corporation, 2000 Galloping Hill Road, Kenilworth, New Jersey to examine problems relating to access to health care in the State. The commission will hear testimony from representatives of labor organizations, the State and private industry focusing on 1) what health care insurance coverage is or should be provided to employees, 2) the difficulties encountered in obtaining coverage and recommendations for improving health care insurance coverage, and 3) the feasibility of establishing a mandatory level of health care coverage.

Address any questions or requests to testify to Robbie Miller, Aide to the Commission (609-292-1646), State House Annex, Trenton, New Jersey 08625. Those wishing to testify are asked to submit 15 typed copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses and the time available to each witness at the hearing.

NOTE: All persons attending must stop at guard house for an entrance pass and directions to the Auditorium.

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

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mjz: 1-118

ASSEMBLYMAN JAMES E. McGREEVEY (Chairman): Good morning, and thank you for attending. I welcome you to this hearing before the Assembly Health Care Policy Study Commission. At the outset, I would like to thank Mr. Richard Kinney and Ms. Linda Pacotti of Schering-Plough Corporation for their hospitality in hosting today's event and discussing this issue. In addition, I would like to thank Assemblyman Jackie Mattison, Assemblyman Nick Felice, and the partisan and OLS staffs who are here to assist us today in examining access to health care in the State of New Jersey.

This is a part of our continuing series of hearings, the purpose of which is to examine the New Jersey health care system and the questions of accessibility and affordability in our State health care system. Today we are going to be focusing, quite narrowly, on the question of the workplace. In addition, we are going to be looking at what health care insurance coverage is, or should be provided to employees, the difficulties encountered in obtaining said coverage, and the feasibility of establishing a mandatory level of health care coverage for all employed citizens.

According to the Department of Health analysis based on United States Census Bureau household survey data, approximately 89% of the State's employed workers aged 18 to 64 had coverage in the year 1986. This finding was reenforced by the United States Bureau of Labor Statistics surveys of medium to large business establishments conducted at various times between the years 1986 and 1988, which revealed coverage rates for full-time workers ranging from 91% in the Newark metropolitan area to 95% in Mercer County and the Bergen/Passaic region.

The other side of the coin is that approximately over 11% of New Jersey's employed workers aged 18 to 64 were without health care coverage in 1986, and by all estimations of the Department of Health this number has grown substantially.

Workers without coverage who accounted for approximately 65% to 70% of all uninsured persons in the 18 to 64 year age group were most heavily concentrated in the smaller service and retail establishments, where employer-financed coverage is considerably less prevalent.

In trying to answer the question of how we should address New Jersey's uncompensated care system, how much should an employer provide for employee health care coverage, and to what extent the employee should share in the premium costs and substantially pay indirectly for the uncompensated care, we are going to be making the following assumptions:

1) That the average cost of an employer group premium combined with individual and family is $4000 per employee/employee family.

2) That medical claims represent 90% of the costs of coverage. The remaining 10% covers administrative costs and profit. This percentage tends, frankly, to be higher in certain instances, namely Blue Cross and HMOs, than for other commercial carriers.

3) Hospital's, namely nonphysician costs, represent 50% of a carrier's total medical claim costs. This portion of claims represented by hospital costs is less for HMOs. Roughly 40% of New Jersey HMO medical claims are for hospital costs.

4) The uncompensated care markup to hospital bills is 18.35. For the first half of this year -- 1990 -- it was 19.4%; the expected markup for the second half of 1990 is 17.3%. If calculating that the average hospital expense per policy is $1800 -- $4000 times 90% times 50%, it comes to approximately $1800. Included within this $1800 would be the $279 which is the contribution toward uncompensated care. So, given the assumptions above, employers who insure their employees and the employees, to the extent they share in premium costs, currently contribute an average of $279 per employee/employee family. If the uncompensated care were not

funded through a hospital markup, the average cost of health care coverage would be expected to decrease from approximately $4000 to $3721.

Mindful of those assumptions, and mindful of the task before us, what we hope to do at today's hearing is to focus narrowly on the question of not only the costs of health care coverage to New Jersey employers, but after ascertaining the number of insured New Jerseyans, somewhere over $850,000, how to bring all employers responsibly to the table of health care coverage.

In that vein, we will call our first witness. Because of her scheduling concerns, we would like to call upon Mary Strong, Chairwoman of The Citizens' Committee on Biomedical Ethics. Mary, thanks for being here.

M A R Y S. S T R O N G: First, I would like to thank you for the opportunity you have afforded the citizens and all of us to be here to talk with you about some of our concerns and some of our ideas. Before I read my testimony, there is something that is not in the testimony, but something that troubles us in the Citizens' Committee on Biomedical Ethics. I think we are going to try to work on it, but I want to put it out to you.

There is no-- One of the reasons I think we are so concerned about how to handle our health care in this country is that we don't have any philosophical base on which to build a foundation of how do we pay for health care, and what kind of health care are we talking about? I think if we could come up with a philosophy-- We did this about education years ago and, therefore, we have public education. We don't have a philosophical foundation on which to build our health care planning.

The other thing is, we talk of health care in the realm as if it were all the same. Really, we have health care which may be prevention. We have illness care, which is

sickness care. They are two different things. I think the semantics of that hinder us in thinking clearly about what we are going to provide and how we are going to provide it.

Now I will read my statement: The primary purpose of the Citizens' Committee on Biomedical Ethics is to create an environment for grass roots citizens' exploration of the ethical issues in health care presently facing individuals, institutions, and policymakers, and to provide mechanisms by which these issues can be broadly communicated to the society at large.

In 1983, five citizens of New Jersey came together to discuss the implications of reports issued by the United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The Citizens' Committee has since been motivated by the conviction that citizens are responsible for their society and, as such, responsible for the systems of health care which form an integral part of a humane society.

Wishing to bring the findings of the President's Commission to the attention of New Jersey's citizens, and in particular to begin to provide a more informed citizenry, this informal group conducted a public forum on October 18, 1983. In the course of the forum, an interdisciplinary panel, made up of ethicists, lawyers, psychologists, administrators, social workers, nurses, and physicians, responded to questions from an audience of 250 citizens. Between 1983 and May 1985, forums were held throughout the State.

The Committee embarked on a statewide project: "Your Health, Your Choices, Whose Decision?" (1985-1987). The operating assumptions which guided this statewide project were, and remain:

1) that cultural, legal, and technological changes have created an acute need for citizens to be involved actively in a public discussion of medical-ethical issues;

2) that information and education are prerequisites for intelligent public discussion, particularly if it is to be sensitive to the needs of a pluralistic society;

3) that to be more effective, public discussions of this kind should take place at the community level so that subsequent public policy can reflect grass root priorities and values.

The Committee's expectation is that the public will play its legitimate role in formulating policy for the design of a health care system that works in the best interest of all concerned.

Health care in New Jersey and the nation faces critical choices. Although our nation spends a greater percentage of its gross national product for health services than other nations, it has not experienced any great access to, or better health for its citizens. Most health experts would agree that at the present time we are indeed rationing health care, although it remains largely unrecognized by the general public. Because of this, the rationing is irrational and not based on any consistent social policy or sound clinical criteria. In order to achieve a better level of social justice, the Citizens' Committee would argue that health care funding choices must reflect citizen values.

The studies which the Citizens' Committee are prepared to conduct would provide health policymakers with information on which to base sound decisions.

New Jersey's Commissioner of Health called for a "comprehensive State health plan" as a means of gaining control over spiraling health care costs while improving access to health care. The cost of health care in New Jersey has risen 60% over the past five years according to the Florio administration.

The Commissioner went on to say the plan must be developed with help from the people of New Jersey who actually should set the health care agenda.

The Citizens' Committee reflects, and will continue to reflect, the voice of the people by hosting public forums for open discussion and by gathering the public's opinion and measuring attitudes, all of which educate the public as well. The Committee can assist the State because of its dedication, activities, and ability in involving the public.

Thank you for your time. My staff and I look forward to your questions and being of any help we can.

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

MS. STRONG: Thank you.

ASSEMBLYMAN McGREEVEY: At this time, I would like to call Gary Yeaw, Director of Group Insurance for Allied Signal.

G A R Y Y E A W: Good morning. I want to thank the Commission for this invitation to speak before you and the public.

My name is Gary Yeaw. I am Director of Group Insurance for Allied Signal, Inc. My responsibilities include the design and development of group insurance programs nationwide for Allied Signal.

As the Commission addresses the issue of health care in the State, there are many facets to that. Certainly, access, quality, and the finance and delivery of health care are key fundamental issues that I think all have to be addressed in any potential reform or solution to the health care problems we face.

What I would like to talk about today is a program that we have developed at Allied Signal which we think provides a more rational method of delivering health care benefits to our constituents. This concept, known as "managed care," we think, in a broad sense, ought to be given serious consideration by the Commission with respect to the delivery of health care within any potential reform or solution.

When I spoke with Robbie (referring to Commission aide) a few days ago, she asked that I come prepared to basically talk about the Allied Signal perspective and story, and she asked that I do that in about 10 minutes. I felt that perhaps the best way I could do that would be to use some slides, and very quickly hit some of the key elements of the program.

To give you a brief history, as we developed this program in the 1987 time frame, historically through the early '80s Allied Signal, along with many employers, had taken what I think many would consider the traditional kind of an approach to addressing health care through what we call an "indemnity" kind of health care program and, indeed, we had made attempts in the early '80s to implement planned provisions designed to attempt to control costs, such as second opinions, precertification of hospital stays, and many of the other traditional kinds of solutions.

What we found was that, indeed, they had a very temporary effect on controlling health care costs, and as we moved into 1987, we were facing what we considered, within our environment, a rather catastrophic increase in health care costs over the coming years, a situation which we felt was unacceptable and had to be addressed.

As we look at health care costs and the delivery of health care benefits-- This slide looks at it from an employer's perspective, but I think it is also apropos to the public sector, in the sense that we have to understand that there are really three parties, in some cases four parties, to the equation: There is the provider of health care; there is the employee, or citizen; there is the employer, or the State, or whatever body that is essentially funding the benefits; and, to some degree, an insurance carrier or other delivery mechanism.

As we address health care, we have to keep in mind that there really are no magic solutions. To the extent that we attempt to reform a system, we really have to keep in mind that we have to address all three elements -- all three parties to the equation. Fundamentally, in the early '80s, many employers had really concentrated on that relationship between our employees and the employer in terms of adjusting deductibles or employee contributions or adding provisions to the program, which we had to believe would influence them to become better health care consumers. I think as we look back on that and we ask ourselves why it had such a short-term effect, I think fundamentally the reason is that the average individual really does not have the wherewithal to be a good health care consumer in the sense that they have neither the knowledge, the purchasing power, or, in some cases, the desire to really attempt to be a good health care consumer. What managed care does is to put into place a delivery system which brings into play health care professionals who can attempt to influence the system before health care is delivered.

Just to quickly try to differentiate the two, under a traditional indemnity kind of insurance program, basically the cost of the services is being for after the fact, reimbursed by the employer or the carrier or the State, whoever, whereas under a managed care environment you attempt to put into place arrangements before the delivery of care that attempt to control both the price and, to some degree, put parameters on the utilization of health care services.

The Allied Signal approach to that is to say: "We want our employees to-- (indiscernible comment about malfunction of slide projector) Our program is what is known as a "point of service" program. Unlike a traditional health maintenance organization where employees are locked into using a network of providers, under our program they are free at any time to go to network providers outside the HMO or PPO network, albeit at a higher cost, which I will show you later.

The key issue there is that-- We talked to many employees, and many said they were willing to try a managed care environment, but, indeed, they didn't want to be locked into using a network of providers which they may or may not be comfortable with. They wanted the freedom to go outside of the network if they felt it was appropriate. This design attempts to get at that in terms of what we call a "point of service program."

Very briefly, if you use the network of health care providers under our program, you pay $10 for a physician's office visit and $5 for a prescription. That is virtually all the cost sharing you have in the network. Outside of the network, each employee will pay a deductible -- an annual deductible of 1% of their base annual salary. Thereafter, they will pay 20% of the expenditures, up to a maximum out-of-pocket limit for the employee of 4% of their base annual salary for the entire calendar year. Clearly, there is a financial incentive to use the network of providers, but just as clearly, I think, if you look at the out-of-network program, it is not far away from the type of indemnity programs that many employers offer today.

ASSEMBLYMAN McGREEVEY: Gary, in the network programs, do you have prearranged agreements with physician groups, with service providers?

MR. YEAW: Yes.

ASSEMBLYMAN McGREEVEY: And they were contracted out prior to the establishment of the medical plan design?

MR. YEAW: That is correct.

ASSEMBLYMAN McGREEVEY: So, you provide your employees with, say, a list of doctors who would accept the Allied Signal health care plan?

MR. YEAW: That is correct, much like the traditional HMO, with the exception that the employees have the ability to go outside the network if they so desire, at a higher cost.

I won't dwell on this, but the dental plan is quite similar.

When you talk about managed care, it is important that the Commission understand that managed care means many, many different things to many different people. And indeed, there are many kinds of managed care. There are individual practice associations, which are essentially contracted groups of physicians who practice in the community; staff model facilities, such as HIP; there are different kinds of IPAs; there are what are called "managed indemnity insurance programs"; and clearly, there are unmanaged indemnity.

A fundamental point here to understand is: As you move toward one end of the spectrum, you limit access and freedom of choice for the employee or the citizen, but you also increase your ability to control costs. We think fundamentally that the most desirable of delivering care is a mix of these systems, utilizing different mechanisms in different ways, utilizing staff models, but also augmenting them with IPA arrangements.

ASSEMBLYMAN FELICE: One quick question.

MR. YEAW: Sure.

ASSEMBLYMAN FELICE: Whem the employee decides to go to the physician of his choice, then does he get exactly the same amount that would be given to the physician under the controlled plan? In other words--

MR. YEAW: No, that physician is free to charge whatever he normally charges.

ASSEMBLYMAN FELICE: Absolutely.

MR. YEAW: And the employee has an annual deductible and pays 20% of that cost, up to an out-of-pocket limit for the year. We have no control over what that physician charges.

ASSEMBLYMAN FELICE: But the employee, for certain types of medical care-- Is he aware in advance what percentage he would be getting before going to an outside -- to his own

personal physician? Is there a chart or a list that says that if you have your appendix removed, there are "X" number of dollars for that under the controlled plan versus going to your own physician under the system?

MR. YEAW: No, but if you go out of the network, you know what your share of that cost, as an individual, will be, and certainly you can calculate that by asking the provider what his charges are going to be.

ASSEMBLYMAN FELICE: Thank you.

MR. YEAW: Just to summarize briefly, we now have, I believe, 30 networks around the country, with about 50,000 employees in those networks, and we are continuing to try to develop networks in different areas around the country.

In terms of how employees utilize the program, what we found was that people tend to either stay in the network virtually all the time, or go into it very seldom. Very few people randomly go back and forth throughout the year, in- and out-of-network, although that is available. Indeed, what we found was, nearly 78% of our people use network providers 90% of the time or more, and roughly 12.3% of employees use the networks less than 5% of the time; a rather interesting development, I think, in that while the point of service program was designed to give people that freedom, typically they tend to skew themselves to one end or the other.

In terms of benefits paid, 83% of the benefits are paid through the network providers. In terms of utilization, we have tried to measure this against some standards. Hospital days per thousand being a relatively accepted measure of inpatient utilization, what we found is that in our health care connection program, our hospital days per thousand are down to 234 days per thousand, versus our indemnity programs of over 400 days per thousand. While that compares to our carriers' book of business of 483 days per thousand, an Inter Study's, which is a research group of HMOs' standard, was 315 days per thousand.

At the same time, outpatient, ambulatory care, we find, is delivered more frequently through the health care connection; indeed, 3.4 ambulatory visits per year -- per member per year -- versus the indemnity program of something under two. Fundamentally, what this is telling us is that we are cutting back of our hospital days, but we are providing a great deal of that care through the outpatient setting.

That is all I have at this time. I would like to continue to entertain any questions you might have. .

ASSEMBLYMAN McGREEVEY: Gary, what is the differential in costs? I mean, you showed the difference between the inpatient and the acute care facility and the ambulatory, and obviously feel the discrepancy between one diminishing and one growing. What is the net physical impact on Allied Signal in terms of provision of those benefits?

MR. YEAW: In terms of our per employee costs, we found that the health care connection has saved us some 23% of costs per employee over what we think we would pay in a traditional indemnity kind of environment.

ASSEMBLYMAN McGREEVEY: Twenty-three percent?

MR. YEAW: Yes.

ASSEMBLYMAN McGREEVEY: And, in terms of the development of the program, could you just explain a little bit of the formation and then the marketing of the program to your employees?

MR. YEAW: Sure. As I said, we embarked upon the program in 1987. We went through a process of selecting consultants to solicit bids from various health care carriers, insurance carriers, and health care management companies such as U.S. Health Care or, at that time, a maxi care. We went through a long process of selecting a carrier. In terms of our organization, we felt it was to our interest to select one nationwide carrier, and we selected Cigna to administer our networks around the country. They are not exclusively Cigna

networks. What we do is essentially Cigna controls the program, but they subcontract in many places around the country, with other health care networks that are available.

We went through a long process of communication with our employees in terms of trying to communicate, first of all, the nature and the magnitude of the health care problem in the United States, and why we thought managed care was a more rational way of delivering health care. Essentially, we think it is moving from being a passive payer of health care benefits to being a more informed buyer, or purchaser of health care. And as I say, a very long and very detailed process of communicating the design of the program, the development of it, and the networks that were available.

ASSEMBLYMAN McGREEVEY: Just in terms of the provisions of nonacute health care -- say, for example, psychiatric rehabilitation. I mean, what is the scope of coverage, say for example, for those--

MR. YEAW: Well, in-network, off the top of my head, outpatient psychiatric care would provide up to, I believe, 50 visits per year; full hospitalization facilities; and with outpatient there is significant cost-sharing, as there is with other medical services.

ASSEMBLYMAN McGREEVEY: And in terms of, say, drug and alcohol treatment and prevention?

MR. YEAW: The same as I just described for psychiatric care.

ASSEMBLYMAN McGREEVEY: Okay. Just in terms of your outpatient utilization, your outpatient hospital-based-- Can you differentiate between hospital-based and non-hospital-based outpatient visits?

MR. YEAW: I can't at this time, no.

ASSEMBLYMAN McGREEVEY: Okay. Then, just in terms of the actual-- What is your long-term-- In terms of your financial indicators, if you could just discuss the solvency of

the system in terms of operation and profit margins, in terms of the overall costs to Allied Signal--

MR. YEAW: We were entering a period where we felt the costs of our health care benefits were going to increase at a rate something in the vicinity of 18% to 24% a year; clearly, far more than any other cost of doing business. Our objective is to -- is not to reduce health care costs, so much as to keep the increase in the cost of health care benefits under 10%, within single digits.

ASSEMBLYMAN McGREEVEY: And have you been able to--

MR. YEAW: To date, we have been able to do that.

ASSEMBLYMAN McGREEVEY: My last question deals with your retirees. Obviously, we are all concerned about Medicare's participation, not only in Chapter 83, but also in terms of private retiree benefits. How does the retiree mix with the Allied Signal health care system?

MR. YEAW: At this point in time, we have not been able to develop a managed health care program that we can effectively integrate for our Medicare-eligible retirees. We have introduced the managed health care system for pre-age 65 retirees, and today we are encouraged by what we see there. But the structure of Medicare is such that it makes it very difficult to develop a private managed care system and to effectively integrate that with Medicare.

ASSEMBLYMAN McGREEVEY: On the reimbursement end, how do you reimburse, say, with the physician-- Is that a direct reimbursement on a patient-by-patient, or is that an aggregate reimbursement?

MR. YEAW: It varies in different parts of the country, but in general, primary care physicians are reimbursed on a prepaid mechanism per member, per month fee, which is age and sex adjusted. Specialists tend to be reimbursed any fee schedule -- prearranged fee schedule.

ASSEMBLYMAN McGREEVEY: Okay.

ASSEMBLYMAN MATTISON: At Allied Signal, instead of just network, do you have any of your employees who are members of unions where you would have to negotiate salary and benefit packages with them?

MR. YEAW: Yes, and indeed we have negotiated this program in some 13 collective bargaining agreements around the country.

ASSEMBLYMAN MATTISON: And they have accepted it and are working within the program?

MR. YEAW: Yes.

ASSEMBLYMAN MATTISON: Okay. Also in the network, is this program set up for all the employees of Allied Signal, or do you have different programs for different levels of employees, i.e., senior management? Are they participants in this program, or do they have a separate benefit package above this package?

MR. YEAW: No, they do not. Our senior management people participate in this program, as do all of our non-bargaining employees, where networks are available. We have some areas of the country where we have not developed networks, but where networks are available, with the potential exception of a collective bargaining situation, all employees participate -- management, senior management, and nonmanagement employees.

ASSEMBLYMAN MATTISON: Thank you.

ASSEMBLYMAN McGREEVEY: Thanks, Jackie.

ASSEMBLYMAN FELICE: I just have one question, Gary. I am very interested in the statistics you had on the amount of networking employees who have out-of-hospital visits. What does that signify? Is there any kind of a study to say, "Well, it means they are getting more preventive medicine by going to their local physicians in the network?" or, "Are the network physicians actually accomplishing what normally is accomplished by the patient going to the hospital?"

MR. YEAW: We think it means all of those things, in toto. We think it means, first of all, through the network, preventive care and things such as Well Baby Care are available, and we encourage providers and employees to utilize preventive care methods. Certainly that would increase the number of ambulatory visits. We also think that we are moving some utilization which one might deem as being utilization which may not have been appropriate utilization of inpatient hospital stays to an outpatient setting for certain procedures.

ASSEMBLYMAN FELICE: Do you think there is an overuse of technology by some of the patients being at the hospital and getting extensive testing that they didn't need before, and that this is sort of reducing those costs because they are not necessary?

MR. YEAW: I think the prevailing wisdom of the studies that have been done generally finds that there is, indeed, some inappropriate use of inpatient health care, as well as the technology associated with that. Many studies would vary in terms of the degree of what is appropriate versus what is inappropriate utilization. What we have tried to do is put into place a system which attempts to monitor utilization and weed those inappropriate admissions out.

ASSEMBLYMAN FELICE: Just one last question: If an employee goes in and out of the network, how do you figure out the deductible that the employee is going to pay? In other words, you have certain employees who are using the network, and then actually going out of the network. Has this been a base figure that they know ahead of time, again, if they go in and out of the network, what their percentage will be? Does it vary?

MR. YEAW: Well, they know what their percentage will be. The variable is what their health care provider out-of-network will charge.

ASSEMBLYMAN FELICE: Right.

MR. YEAW: Basically, when you go in the network, the financial arrangements have been arranged in advance so that you put your cards on the table and you shouldn't, under ideal circumstances, even see a bill. When you go out-of-network, you have to get a bill and submit a claim, as you would under a traditional insurance program, and those claims will accumulate to the point where you meet your deductible, and then you will pay 20% of the bill as your coinsurance, as it is called, up to a maximum per year. For a catastrophic situation where your maximum is a stop loss as an employee, it is 4% of your salary.

ASSEMBLYMAN FELICE: Doesn't that get confusing when you are taking a percentage of the base salary, though, as a figure?

MR. YEAW: No, not particularly. We have not found that to be problematic.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: It is interesting, because some of the suggestions that you have set forward are very similar to those of the Garden State Health Plan in this State, in fact, the HMO.

Even though it is not the subject of today's hearing, I just have two questions regarding your interaction with Chapter 83 and the DRG system: Do you have any independent agreement, or have you negotiated any independent agreement or an all-inclusive price per case with hospitals?

MR. YEAW: In New Jersey, because of the Chapter 83 environment, we have not been able to do that.

ASSEMBLYMAN McGREEVEY: But, in other states?

MR. YEAW: In other states, we would. I think there are different opinions on the DRG system. One of the difficulties is, it does not allow a payer, or a group of payers, to attempt to influence the system through -- to put downward pressure on the system through the ability to negotiate arrangements. While Chapter 83 technically allows

that, in reality the structure is such that it really isn't feasible.

ASSEMBLYMAN McGREEVEY: Do you have, say for example, within-- Negotiating with other hospitals statewide, have you established a system whereby you can allocate what would constitute an average cost nationwide for treating a particular DRG?

MR. YEAW: We have DRG costs nationwide. I am not sure I understand your question completely.

ASSEMBLYMAN McGREEVEY: Well, I mean, so, you negotiate against a stable price nationwide?

MR. YEAW: It is not just what you think nationwide your costs are. It also has to take into account the local environment and regional differences.

ASSEMBLYMAN McGREEVEY: Okay. Just out of curiosity, is there a significant difference, say for example, in Pennsylvania or neighboring states between the explicit reimbursement rate for hospital costs and the DRG rate? I would be interested in--

MR. YEAW: Let me answer that by saying what we found is that there are quite large differentials in the costs of health care among regions. Indeed, you know, we find that the costs of health care on the East Coast and on the West Coast are substantially higher than, for instance, mid-America or southern America. Relative to hospital costs, I am not sure we have reached any conclusions in that respect.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. YEAW: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much.

At this time, we would like to call on Donald McCambridge, Director of Human Resources Services for the New Jersey State Chamber of Commerce.

D O N A L D L. M c C A M B R I D G E: Good morning, Chairman McGreevey and members of the Assembly Health Care

Policy Study Commission. First I wish to thank you for providing this opportunity to share some thoughts on this vitally important subject of health care issues. Secondly, you have my admiration for attempting to establish an understanding, then analyzing and sorting out viable solutions and developing recommendations which will be palatable to all sectors of the State. That appears to be a monumental task.

I am Donald McCambridge, Director of Human Resources Services for the New Jersey State Chamber of Commerce. I have had the privilege of being in the human resources profession for 30 years. My experiences have been varied, and I will not bore you with a recitation of positions held. Please accept my statement that I have served in the profession and have witnessed dramatic change since 1960.

We are all well aware of the problems confronting our State. Situations such as budgetary shortfall can be dealt with in a short time frame. Environmental problems such as cleanup, etc.-- It will take years before the dawn of success will be seen. Yet we shall meet these problems and identify solutions which might be momentarily bitter, but in the long run satisfying.

But what about health care? How will our citizens maintain their healthful standard of living with medical costs continuing to rise: medical insurance premiums rising annually; employers changing the insurance mix, increasing deductibles, forcing a shared premium, or simply discontinuing the health insurance program? How can those who work full-time but have no company insurance or those who work part-time or no time at all and have no insurance realize proper medical care?

These questions are being asked by you as members of the Commission, by employers, employees, and those not employed. Some responses are to mandate that every employer in the State provide health insurance. Some will answer that we should have absolute freedom from interference from government

and permit a totally free economy for health insurance. Obviously, the fittest would survive; the less than fit would perish.

Honestly, the first suggestion, in my opinion, would not only stifle business development and economic growth, but would strangle the employers in New Jersey.

The second suggestion is nearly as bad because the survival of the fiscal fittest would prevail and some would enjoy insurance and appropriate health care to the fullest, while some members of our society would not have insurance, could not afford proper medical care, and this would destroy any hope for our future in New Jersey.

It should be apparent that what I suggest is somewhere between these two intolerable extremes. I do not believe that mandating an employer to provide health insurance is a viable solution, nor is the government stepping aside and permitting a survival of the fittest. What, then, is something in-between?

First, I firmly believe government should take their super enlarged foot off the accelerator and slow down. The situation we have concerning health insurance and health care availability did not happen during the last session of the Legislature nor term of Governor. It has taken some years to get to this point, and applying a Band-Aid of mandating health insurance is as useless as placing a Band-Aid on a severed limb. The Legislature should be the guiding light of reason and practitioners of long-term planning to confront problem situations and establish solutions which will work and, if not, then can be adjusted without scrapping the entire program.

Employers need incentives to meet problems as all humans need incentives to perform. Many are in business for they identified a need and developed a product or service to meet that need. Health care insurance can, and should, become the instrument to satisfy a need of the employee. But shoving an insurance policy into the hand of the employer while

reaching into the wallet for premium dollars and then telling the employer that this is an example of good citizenship and good business, is totally unrealistic.

Government should implement positive incentives for the employer to take advantage of when providing insurance packages; not negative, not a position of additional tax on earnings if insurance is not provided, but positive incentives such as tax credits to be used for expansion of services or production which, in turn, will employ more people. Thus, no health insurance plan provided, no incentive granted. Health insurance plan provided by the employer, then incentive earned by employer, but only to be used for business development which will generate more jobs.

The government could also put a freeze on the continuing accumulation of mandated benefits. I do not know if we have enough coverages, too many, or too few coverages. I do know in every session of every Legislature we have a slate of bills suggesting even more situations be brought under the umbrella of insurance, thus adding fuel to the fire of rising premiums.

Let's pause and reflect upon what we have or do not have: I might suggest that what we need are several models of health insurance. These models would begin with a no frills insurance that would be affordable to individuals as well as small employers; with perhaps another model with more benefits which employers who could afford to, would purchase and provide to the employees. And then, of course, the top of the line, a model of an all-encompassing program that would cover everything.

The three models or maybe five, would not be discriminatory, for even the bare bones, or no frills model, would provide insurance coverage for medical care to get the person healed and back to a normal life. And that is the objective -- the original objective of health insurance.

One major situation we have not touched upon is the Uncompensated Care Trust Fund. I believe it is admirable that New Jersey's government believes that anyone who is ill or injured should receive proper medical care regardless of economic status or insurance availability. I must also express my disappointment that the authors of this program, some years ago, did not adequately fund the program.

At present, the blame for having people utilizing Uncompensated Care Trust is directed at employers. It is the employers who first of all do not hire a sufficient number of people. It is the employers who even when they hire people do not provide insurance programs. Therefore, it is the employers who should pay for those people who become ill and need medical care. The medical provider receives the fees from the Uncomensated Care Trust Fund, so they do not have a loss. The employer pays via the ever-increasing insurance premiums of health insurance, because of the current 14% tax on medical bills which ultimately are paid by insurance and thus are rolled into the premium structure.

If this is a societal problem, then all sectors of society should share in the support of the Uncompensated Care Trust Fund, not just the business community in general and employers specifically. We suggest that funding for the Uncompensated Care Trust Fund might be more appropriately supported from general revenues.

Your task is not an easy one, and I respect your willingness to listen and discuss the issues. Several other states have wrestled with this situation: Massachusetts, as we all know, is in the throes of reorganizing their plan; Connecticut has just inaugurated a plan with much fanfare; California is diving into the murky waters; and the Federal govrnment is also developing thoughts. To assist your staff, we have provided some information concerning these programs.

To sum up our position, we at the State Chamber of Commerce do not recommend that mandatory health insurance programs be placed on the employers. We recommend to you, the entire Legislature, and the Governor that incentives be developed to sell the employers on the principle that providing health insurance is good business. We recommend that insurance companies be called upon to develop models of insurance programs which will not necessarily cover all of the mandated benefits, but will be affordable.

I am going to skip off my prepared text here and make mention of something that I wasn't going to do, and then I thought maybe I would: We at the State Chamber of Commerce instituted, a little over a year ago, through an insurance provider, the opportunity for small businesses to buy insurance programs -- basic insurance programs -- following all the precepts of the law and so forth, but the small employer has an opportunity to buy in. In something just under a year, we have sold well over 100 policies. I think they are averaging somewhere around 10 to 12 employees per group. These are affordable health insurance programs being offered through us to our members, specifically the small business community. We are running now at about 10% to 12% under average on the premium, and we are looking for an even further reduction because we are going to go experience-based very shortly.

This type of operation can be done. It just takes a lot of effort and a lot of development.

Lastly, we recommend strategic planning with short-term and long-term objectives and appropriate planning concerning health care issues. There is really no quick fix.

There is an adage of some age which says: "Why is it we have enough time to do a job over, but never enough time to do a job correctly the first time?" This time let's do the job right the first time and then build our society on that solid base.

We do appreciate this opportunity to discuss our feeings with you. We at the State Chamber stand ready to assist you if you desire. One only needs to ask.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. McCambridge. If you could just answer a few questions-- One, I see that you are concerned with the mandating of benefits. Providing we can figure out how to afford an incentive, what is to stop an employer from walking away from health care coverage, even granted an incentive?

MR. McCAMBRIDGE: In all honesty, there is nothing to stop him. But we also have a law on minimum wage, and I am sure that on average there are employers who are paying less than minimum wage.

ASSEMBLYMAN McGREEVEY: Then they should be prosecuted.

MR. McCAMBRIDGE: That's right, but one has to have investigators to go out there to determine that, the same way with the health insurance.

What I am saying is-- Well, way back many years ago, I came up with the philosophy of 90/10. I found out that an Italian economist had a better one called 80/20. Whatever you do and whatever you get into, you are going to have 10% of the people either violating the law or ignoring proper precepts. And you are going to have that in the employer community. What we are recommending is to develop these incentives to reduce that 10% of walkaways to as low as we possibly can. Obviously, it is going to take a lot of work and a lot of input by a number of people to put this thing together. However, we believe it is workable and would be much more palatable to the employer community, other than a mandated position.

ASSEMBLYMAN McGREEVEY: But, I mean, you mentioned yourself, Mr. McCambridge, that the employer pays in ever-increasing insurance premiums, including the numbers for 1990. As I understand it, we are looking at an increase in the uncompensated markup to an average of 18.35%. The concern I

think you have is that the add-on is creating an unfortunate burden on those who do provide health care coverage.

In terms of addressing the disproportionately large numbers of those insureds who are employed, how do you responsibly address that inequity without mandating a level of participation for hospital insurance?

MR. McCAMBRIDGE: Well, we don't necessarily believe that mandating an insurance policy is going to reduce the cost. We want a freer economy.

ASSEMBLYMAN McGREEVEY: But won't it bring more people into the health care insurance system? It obviously has to.

MR. McCAMBRIDGE: Well, obviously it has to, right; right. We are now talking about a figure of something like 850,000 people in the State of New Jersey who are uninsured. Those are the numbers I have heard. Yes.

If the Legislature and the Governor implement a program that everybody has to buy insurance, obviously, yes, we are going to have 850,000 people, not a total--

ASSEMBLYMAN McGREEVEY: Excepting those who are medicated in the--

MR. McCAMBRIDGE: Right, right, okay. We are going to have a large sum of those people under insurance programs. In all likelihood, the premiums will continue to rise at the rate they are already going, because, secondly, some of those people -- a lot of those people -- are in the process of spending close to $700 million a year in the Uncompensated Care Trust Fund. And I just did a quick calculation -- which is not statistically significant necessarily -- but you take the 850,000 and divide it into 700 million, and you come up with $824 per year per person spent in medical care. That's a pretty heavy per person expenditure.

ASSEMBLYMAN McGREEVEY: The Department of Health would disagree with your figure, but the point of the matter is, in terms of what we are trying to do here, recognizing that

significant work has to be done with insurance companies, and significant work has to be done to provide affordable health care insurance to the small businessman in terms of managing employer group premiums-- In attempting to reduce the costs for uncompensated care, obviously we want to bring more people into the system. My point, which is a simple one, is: Incentives will not bring as many people into the system. And secondly, when you talk about general revenues, what physical mechanism, or what fiscal incentive can be provided to employers specifically to bring them into the system that you think will work?

MR. McCAMBRIDGE: In a very short time frame, we want to deal with the whole incentive program. One, my point is, mandates we do not believe work.

ASSEMBLYMAN McGREEVEY: Okay. Accepting that for a second, what specific incentives would you have the State, if you could be Brenda Bacon for a day-- What specific health care incentives would you have--

MR. McCAMBRIDGE: Well, providing that the employer, especially the smaller employer, provides insurance -- health insurance -- which then eases some of the other problems, then there would be a certain amount of tax credits given to the small businessperson. There isn't a small businessperson in the world who isn't looking for money; money for expansion, etc., etc., etc.

Via the tax credits, via our own Small Business Administration under the Department of Commerce to develop this program of tax credits for the development of a business because the employer provides insurance packages to his people, we can then provide money to the small businessperson to enlarge, to broaden, to develop, to create more jobs.

ASSEMBLYMAN McGREEVEY: But it is going to be cheaper-- Obviously, Mr. McCambridge, it is always going to be cheaper not to provide any health insurance because the

incentive is never going to meet the costs for health care coverage. So I mean, if you are looking at it in purely economic terms, the small businessman who does not provide health care insurance because of fiscal reasons, will never find a fiscal incentive large enough, unless it is one that out-paces the costs for health care coverage.

MR. McCAMBRIDGE: But we have found that the small businesspeople in our program are buying into our program, are providing insurance.

ASSEMBLYMAN McGREEVEY: Why?

MR. McCAMBRIDGE: Because they feel it is good business to do it for their employees.

ASSEMBLYMAN McGREEVEY: Okay. So they are attracting a better caliber of employee?

MR. McCAMBIDGE: Right, and that is part of the incentive. The other part of the incentive which we look to the State to help out on, is to give additional incentive through some sort of tax credit or financial support, so that they can even do more, and that is build another building, hire five more people.

ASSEMBLYMAN McGREEVEY: And how much would this tax credit cost the State of New Jersey?

MR. McCAMBRIDGE: I'm sorry. I am not prepared to get into that. Those are the kinds of details that have to be hammered out.

ASSEMBLYMAN McGREEVEY: Well, if you can suggest that the Chamber is willing to back a corporate tax in order to pay for this incentive, you'll make a landmark--

MR. McCAMBRIDGE: Yes. Obviously, I am not suggesting that.

ASSEMBLYMAN McGREEVEY: Mr. Mattison?

ASSEMBLYMAN MATTISON: No questions.

ASSEMBLYMAN McGREEVEY: Nick?

ASSEMBLYMAN FELICE: Yes. I have to agree with you on one point. Being involved in a small engineering firm for many years, you do one of two things: Most employers are looking-- The good employers who you want to keep have to do one of two things: You have to provide some kind of benefits or services, or you have to give them a higher salary. It boils down to, if these people are going to stay, the type of people you want to continue your business, you are going to have to do something to keep them. The hardest thing in any field -- professional or otherwise -- is to keep good people. All they need is for one of the employees -- for either their wife or a child to get sick and find out they have become completely drained financially because the company they worked for, small businesses in particular--

You are going to find that at the first opportunity, if someone offers them the same money, but with other benefits such as health care, you are going to lose that employee. That's history. So I think small business, not only in New Jersey, but after meeting with other states, is looking for some assistance to provide health care at a minimum cost to them, so that they can keep the good employees they need to run their businesses. That is what it amounts to. And these states are all coming up with reasons, or a need for this incentive.

The only other question I have is: This plan that the State Chamber has, are you funding the plan completely, or are you going out to an insurance provider and making a negotiated contract? How is that working?

MR. McCAMBRIDGE: Very, very quickly, what we offer to our members is an opportunity to select one of two different medical plans, life insurance, dental, and pharmaceutical drugs. This is from a major insurance provider here in the State of New Jersey. It is handled through a broker and independent agents. We have also moved into providing to small employers prototype retirement plans which cover defined

benefits and defined contributions, 401 concepts and so forth. We are now moving into being able to offer section 125 implementation for further insurances. Let's see, is that it? Yes, that is about it for right now.

My intention, when we got into this and started talking to the broker and to the insurance providers, was to be able to provide to the small businessperson a package similar to what our friend from Allied Signal can do, except that the guy who is going to buy it is going to maybe have five or six employees.

It has been working; it has been working well. Our members are happy, and our broker is happy.

ASSEMBLYMAN McGREEVEY: Have you worked at all, Mr. McCambridge, with health insurance pools for small businessmen which I have seen other states do very successfully?

MR. McCAMBRIDGE: We have not. This program is not an employer-based pool as such. This is an individual situation, and we have now written enough premiums that we are going to go on experience-based, which we feel -- the broker and the insurance provider feel will provide a further reduction in our premium costs to our members.

ASSEMBLYMAN McGREEVEY: Is it along the lines of the managed health care program of Allied Signal, or is it a traditional fee-for-services--

MR. McCAMBRIDGE: No, right now it is a straight indemnity. I have a feeling that I may be calling our friend from Allied Signal to try to talk to him to see if we can't work something out in our own program for the members of the State Chamber.

ASSEMBLYMAN McGREEVEY: Thank you. I just want to say that we will be working with the insurance community. Obviously, the threshold concern is making insurance affordable for the small businessman.

MR. McCAMBRIDGE: Right.

ASSEMBLYMAN McGREEVEY: I think that is a primary concern. But then there is also the flip side: How do you bring that small businessman, provided you can have affordable health care insurance-- How do you bring him responsibly to the health care insurance table? That is the question we have to resolve before December 31, 1990.

Thank you.

MR. McCAMBRIDGE: Right, okay.

ASSEMBLYMAN McGREEVEY: Jim Schroeder, from the New Jersey Education Association.

J A M E S E. S C H R O E D E R: Good morning. Thank you, Mr. Chairman and members of the Commission.

I am Jim Schroeder. I am Associate Director of Government Relations for the New Jersey Education Association. The NJEA represents 134,000 active and retired professional and educational support personnel who work in New Jersey schools and colleges. I am here as a surrogate this morning for our President. Betty Kraemer. Betty, who sits on the Governor's Commission on Health Care Costs, wanted to be here, but is currently on other Association business out-of-state.

In her capacity as a Commissioner, Betty, along with Chairman McGreevey, has heard voluminous testimony from various groups with regard to problems facing our health care delivery system. These problems are myriad and their effects are far-reaching.

NJEA is very interested in working cooperatively with the Governor and the Legislature, as well as health care providers, practitioners, and consumers in order to meet these problems head on. Let me first address what we perceive to be the most pressing problems. Generally we see these problems as relating to access, cost, and the unfair manner in which that cost is presently borne.

First and foremost, health care costs are increasing far too rapidly. These dramatic increases are creating

undesirable economic dislocations. Increasing portions of our society are going without insurance or are underinsured. The Federal government's diminishing role as a partner in health care funding has exacerbated this problem and set into place dynamics which have brought on a crisis situation.

Secondly, let me say that the problem is not with employees and their health care coverages being too liberal. NJEA rejects that notion and vehemently opposes any diminution of benefits by cost shifting through higher deductibles and co-insurance. Such proposals are not a solution and there is growing evidence that they are, in fact, part of the problem.

New Jersey has been a leader in establishing health care policy to ensure that none of our citizens are denied needed health care. This exemplary policy should be continued. Unfortunately, the method of funding that policy has become terribly inequitable. Moreover, like the infamous JUA, too many New Jerseyans are dependent upon that fund for their heath care coverage. Almost on a daily basis, the burden of paying for a growing uncompensated care pool falls heavier and heavier on a progressively smaller group of people. The base for funding our Uncompensated Care Trust Fund must be broadened.

The current funding mechanism for the Uncompensated Care Trust Fund relies too heavily on surcharges paid by workers, employers, and consumers who carry insurance or pay their hospital bills directly. Consequently, responsible employers are subsidizing irresponsible ones -- those who do not provide health care for their employees -- under the current system. This is not fair and puts the responsible employers at a competitive disadvantage. It also adds millions of dollars in costs to the premiums of the insured or paying population, while allowing others to evade what should be a universally shared social obligation.

The NJEA, therefore, wholeheartedly supports efforts through mandates, penalties, and/or incentives to require all employers to provide a health care program for their employees and dependents. The NJEA additionally supports providing maintenance of health care coverage for the temporarily unemployed. This could be achieved possibly through the taxing mechanism of the Unemployment Insurance Fund.

Through employer mandated coverage and by providing for the unemployed population, hopefully the current pool of persons serviced by the Uncompensated Care Trust Fund can be diminished significantly. These actions should lessen the ever-increasing pressures and antagonisms that health care costs are generating on labor relationships. It will also provide a more even playing field where the costs for our policy of universal access are shared far more equitably.

A second question that follows then is: If the State of New Jersey is to adopt a policy of employer mandated coverage as we suggest, what required level of coverage is appropriate? Ideally we should want to encourage a system which emphasizes less expensive outpatient, preventive care, and early intervention, as opposed to more expensive inpatient acute care.

Over a period of time this clearly should be our objective. In the short run, however, it may be necessary to put into place a system which has a mandatory "floor" level of coverage for the employed and temporarily unemployed which is equal to the reimbursement for care currently rendered through the Uncompensated Care Trust Fund.

Individuals would at last have some basic source of medical coverage. That coverage might also include prenatal and maternity care.

Employers unilaterally -- in a nonunion environment or through collective bargaining -- can always raise levels of coverage beyond a basic plan. Once we have had a chance to

assess the impacts of statewide employer mandated coverage, modifications can be suggested to move toward a more preventive/early intervention care model. At a minimum, employers who do not provide basic coverage for employees should be charged a fee per employee paid directly into the Uncompensated Care Trust Fund. The fee should be set at the same level that responsible employers and other payers are paying into the Fund through their premium dollar for hospitalization coverage.

You have asked us to focus on one component part of this far-reaching problem. We are appreciative of the opportunity to proide input and look forward to working with you in the future as the Commission moves into other aspects of our health care public policy.

ASSEMBLYMAN McGREEVEY: Thanks, Jim. A couple of questions from me, and I think the other members of the Commission also have some questions.

You talked about the mandated floor. Could you be a little bit more explicit?

MR. SCHROEDER: Well, there is no plan designed under the current Uncompensated Care Trust Fund. Clearly, I think it is a bold step if you are going to go to some sort of a mandated -- employer mandated -- program, so we think you have to tread carefully. Certainly, people should get no less than what they would get under the Uncompensated Care Trust Fund. Now, currently, that would mean you could go to the hospital and get services. Certainly at a minimum, you should get that.

Now, if we can play around with plan design and get into some things where you can provide some services through outpatient care, or some preventive type care, that would certainly be commendable, but--

ASSEMBLYMAN McGREEVEY: So, would you be-- I think Mr. McCambridge and I think Gary Yeaw from Allied Signal talked about the importance of managed care. Would you want to

provide legislative incentives for managed care if, say for example, you agreed with the premise for the need for mandating certain levels of health care coverage? Would you create an incentive for managed care within that coverage?

MR. SCHROEDER: To tell you the truth, our members-- Primarily, about 70% of our members are in a State health benefits program. They have the indemnity plan; they have a HMO; and they have a PPO. We like the options they have. I heard the testimony this morning with regard to Allied Signal's program. I think it is commendable. I think you have to have choices. Whether or not providing incentives to move in the direction that Allied Signal has gone is the way to go, I am not prepared to say, but I do believe that choices are necessary. I think that is very important.

ASSEMBLYMAN McGREEVEY: Sure. On the question of the rising costs for the small employer in terms of his group premiums, I think the Chamber -- Jim Morford and Bill Elliott traditionally -- talked about the cost; the fact that those 877,000 people are uninsured, or the 70% who are employees, either because of the nature of the risk pool of those employees, or because of the fact that their employer finds it difficult to pay for those employee health care premiums--

What do you do to make health care insurance more affordable to the small employer, if you would mandate benefits?

MR. SCHROEDER: Well, I think first of all, we have to get more people paying into the mix, because right now Blue Cross and Blue Shield have said that 30% of the hospitalization portion goes into the Uncompensated Care Trust Fund. As long as you have that and you have a burden that is growing on those who are trying to participate--

ASSEMBLYMAN McGREEVEY: We are going to tie a dollar amount to whatever more they get. They are going to have to reduce their premiums. Now, what do you do? I mean, how does it work to create a better risk pool?

MR. SCHROEDER: I'm sorry I don't have our technician here today. He could probably answer that better than I. Again, just as a layperson, my reaction is, we have to find a way. I just don't think it is fair. I don't think we can continue to have a system where so many employers can opt out. If we maintain the status quo, we are going to have more opting out. I think that just cannot be continued. More people have to become involved.

I agree with some of what I heard earlier. I think you are already seeing individuals make decisions, changing employers, in order to have health benefits. Just an anecdote quickly: I got my hair cut on Sunday. The woman who cut my hair said she was going to be changing jobs; she was going to an employer who provided health benefits. She related the story that she had just recently had bronchial pneumonia. She didn't go to the doctor right away, but when she finally went to the doctor, the situation was such that he chastised her. He said, "Why didn't you come sooner?" She said, "I didn't have the money."

That is a small anecdote, but I think people are voting with their feet, in terms of changing jobs. The need for health care is so vital. There is a lot of activity out there and a lot of dynamics. You know, you have a difficult task. There is no question about it. And some difficult decisions are going to have to be made. But clearly, the status quo is unacceptable.

ASSEMBLYMAN McGREEVEY: Jim, the last question I have is on the health care coverage for the temporarily unemployed. You are advocating something similar to the Unemployment Insurance Fund.

MR. SCHROEDER: Yeah, and I tried to get some numbers yesterday, just to see how that would play out; what the costs would be. I am not talking about the structurally unemployed. I am talking about the temporarily unemployed. I was unable to

get that. But we do feel that would helps. We have to diminish the number of people who are relying on the Uncompensated Care Trust Fund, and we think that possibly that would be an approach that might work. That would go hand in hand with some sort of an employer mandated coverage.

ASSEMBLYMAN McGREEVEY: Jackie?

ASSEMBLYMAN MATTISON: Do you think the citizens of New Jersey would be prepared, or would be willing to have another tax increase at this point in time?

MR. SCHROEDER: Well, I heard earlier about general revenues. From what I read, I don't think that would be a very popular approach.

ASSEMBLYMAN MATTISON: Do you have any other approach, other than a taxing mechanism?

MR. SCHROEDER: Well, when I say taxing mechanism, this is through the Unemployment Insurance Fund. We would have to see the numbers, too. We just think that would complement an employer mandated program. We are recommending an employer mandated program, as opposed to going to general revenues, probably in part because it is politically not feasible, and we think there are a lot of employers out there getting a free ride. The business community might not appreciate my saying that, but I think there certainly are quite a number who are not paying their fair share. Those who are responsible and are providing benefits are being adversely affected by the fact that others are sitting on the sidelines.

ASSEMBLYMAN FELICE: Some of the factors and statements you made are absolutely true. One of the things that happens, even though an employee who leaves a position has the right to continue for two years to pay -- co-pay into the existing plan that he or she was under- What happens, unfortunately, if a person is laid off or changes jobs, sometimes for a period of three to six months, the last thing they are really looking to do is pay for health care.

Consequently, that is usually when something happens, when a person does not have any insurance at all.

Many years ago, an unrealistic young legislator put in a bill that said that people who were collecting unemployment checks -- that somewhere between $15 or $17 of that could be put into a general plan to give minimum health coverage. I'll tell you something: I never got so much mail. The repercussions-- I said, "What am I doing wrong? I thought that was a good idea. With $15 or $17, at least they would have some health coverage." Of all the bills that I ever put in, I think I had the most repercussions on that one.

But, when you look at it realistically, you are talking about people who have held jobs sometimes for 15 or 20 years, and for some reason the company either merges, or moves out, and they are in a position now where they have a mortgage, or other financial problems, and one of the first things, unfortunately, that people set aside is their health coverage, figuring that they are going to be healthy forever; that nothing is ever going to happen to them. Unfortunately, that is exactly when it does happen.

I see something in unemployment. Those are not people who are irresponsible, who do not hold jobs, or do not have the ability to work. It is that they are in an interim transient type of a situation. I would like to see that come back some day; that during that period of collecting unemployment insurance compensation, that those people -- actually a small percentage-- I would like to ensure that they get at least minimum health coverage, because it seems when you least expect it, is when you have a health care problem.

I think that is the kind of thing that people are looking to ensure. The simple answer is: Get more people off the Uncompensated Care. I think it is one of the greatest things that the State of New Jersey ever did, but at the same time, it was never meant to handle the capacity of people who

are working and have the ability to contribute, even on a co-pay plan, to get health insurance. I think that is the direction we have to go once we figure out how to get that money.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Jim.

MR. SCHROEDER: Okay.

ASSEMBLYMAN McGREEVEY: Next will be Maureen Lopes, Vice President of Health Affairs, New Jersey Business & Industry Association.

M A U R E E N L O P E S: Good morning. Bruce Coe, President of the Association, was invited to be here today, but he was unable to attend. He also has been involved with the Commission quite a bit.

What I would like to do, if it is all right, Mr. Chairman, is-- I have handed out my prepared remarks, and I would like to go through some of the highlights. But I had an opportunity yesterday to hear a presentation by the Robert Wood Johnson Foundation on what is happening in some other states, and I felt there were some interesting lessons to learn there that I would like to share, but didn't have a chance to type up. So if that is all right-- Okay? (no response)

Just to highlight some of our concerns, which may not be a surprise to everyone here-- I divided up the testimony into the three major questions that were outlined in the notice for the Commission's public hearing today. One of the points I would like to make on the first page here is: We are talking about the need for research to identify what the key preventative care services are that make a difference to our health. It gets back to, we do not have a consistent definition in this State of what a basic plan is. What do we mean by bare bones insurance coverage? Whether we convene a panel of physicians to develop that, or how we do it, I think it would be very important, and really help the public debate,

and help us in the future when looking at mandated benefit bills also. So that is one of our suggestions here.

Also, one of my particular points I would like to make, on the second page here, is, even if everyone in this country had health insurance, that would not mean that we had a healthy population; that insurance is a payment mechanism; that we still have an individual choice in how we take care of our own lives. So, I also think we need to look at the total picture of our societal needs; that we need funding for better nutrition and housing. We know that these are major problems, and drug abuse treatment, and drug prevention programs, those sorts of things.

I hope the Legislature puts out in a context that health is a very important social need, but that there are a lot of other ones, too. Somehow we have to figure out, as a State, how we can afford all these pieces.

In obtaining health coverge, I will echo the Chamber in saying that we think affordability is the big problem in New Jersey. We would contend that a lot of businesses are not bad or irresponsible; that they are looking at what those premiums may be. You are using an assumption of $4000 a year for family coverage. That is a very big chunk of money for a small businessperson. There has been a lot of press coverage. I, personally, would have looked at those series in The Star-Ledger, and if I didn't have health coverage, I would say: "I am not even going to touch this problem. It scares me to death."

So I think we have to change that perception; get the whole system under control, so we can talk to people about the fact that this is a system that can move forward.

I would also like to commend-- I have had a chance to look at the recommendations of the Health Insurance Association of America for some of the reforms in the underwriting practices. We have been having further discussions about

that. I think there are some real opportunities there to look at how you deal with high risk individuals or people who are changing jobs, pieces that have added to the costs of insurance coverage, particularly for small groups.

I think that industry, the health insurance industry is trying to step forward with some underwriting reforms, which are definitely needed. We would like to see help for them.

Let's see-- One of the things that I would like to get back to on page 4 here is, in earlier testimony, we talked about the fact that there are not multiple employer trusts in this State. I know both Robbie and I have been trying to figure out why that is. I have had someone say to me, and I don't know how to research this, that part of the problem seems to be that there is legislation that says if you are going to offer life insurance to small groups, you must have a minimum of 10 employees in that group. Now, a lot of insurers offer a package of life insurance and health insurance, so they have said to their small groups, "You must have at least 10 in here to get our offerings." So it seems to be a life insurance issue, and there is some vague language that ties the two things together. That has been constraining the market there. So that may be the place to look, and I can try to get a particular citation on that.

So, it is almost like a myth exists out there that there is a preclusion on 10 and under for health insurance that is really tied to life insurance, so that may be positive.

When we talk about moving on to the idea of mandating health insurance, we, of course, are very concerned about the fact that we see labor dollars as a particular pool of money in any given company. If you start upping the benefit costs, something is going to happen on the wage side. Either you are going to hold down wage increases or you are going to lay people off, depending on how you structure the mandate. And I think that is something that has not been defined either.

Is the mandate just on full-time employees? Is it on part-time employees? I wonder if Allied Signal provides health insurance for their part-time employees, or at what level they do? Is every part-time bus driver for school districts provided with health insurance? Would you mandate that family coverage be included also? That makes a big difference in the premium? So in this discussion, I think we have to start narrowing in on what does that mandate mean, and whether those groups, if they were brought in under insurance, would make a difference to uncompensated care?

I just refer here to The Star-Ledger articles over the past few days that our competitiveness, all the different costs we have in the State, whether for housing or for other things, are having an impact, and so we are very concerned about putting another mandate onto small businesses. We have had an opportunity to talk to even our biggest companies about, "Aren't you upset with the fact that you are paying the surcharge, and maybe a lot of small companies are not?" Their feeling was that small business is an engine for this State; that the big companies sell to those companies, or they buy services from them. If we start jeopardizing their financial survival -- the small business community -- we jeopardize--

ASSEMBLYMAN McGREEVEY: How do we pay for the Uncompensated Health Care Fund then?

MS. LOPES: Well, I guess one of the difficulties of today's testimony is not for us to put forth a plan at this time, that we are having those discussions with the Commission, and I feel reluctant to do that. If Bruce were here, he could decide to do that, but--

What I would like to do now is share some of the things from Robert Wood Johnson, particularly on small business insurance. This was Jeffrey Merrill, who is the Vice President at their Foundation, who has been responsible for a demonstration project they have done. They funded 15 proposals

around the country, 10 of which are very much up and running. All of those proposals ended up focusing on reducing insurance costs for small business as a way to reduce uncompensated care.

There are two ways you can approach it, of course: You can limit benefits and/or you can subsidize premiums. When they talked to insurance companies originally, the estimate was that the small business group market cost 20% more at a minimum compared to a large group. So right there you have a disincentive for small businesses to provide insurance. It is a lot more expensive than it is if you are a big group. Those costs are related to higher administrative costs, marketing, higher claims experience, and just the law of large numbers which works against the small business unit. Ten thousand employees is a much bigger group to spread risk across.

There are a range of programs. I have provided for you -- I will just point out -- attached to your testimony-- First I will talk about the Denver SCOPE Program. I received from Colorado a clipping from last August -- 1989 -- which basically describes the program. This is the most private plan of those that were funded, in the sense that there were very little public dollars supporting this. They were able to come up with a limited benefit package to do this in one way, but what I like about this is that the package is, first, dollar coverage for preventive care and doctors' visits, and then catastrophic, and they define that as over $5000 in hospital costs.

In-between there, people need to come up with some of their own dollars for just outpatient if it wasn't a particular package of services. They claim that that is a combination that had not been put forth before for the business community. The report we got yesterday was, "The phones rang off the hook when this was offered." They had no idea. I mean, that is what I love about this Foundation. They do demonstration projects to give us real life information. "The phones rang

off the hook." They probably had 3000 lines, it looks like so far, in less than a year. That is a tremendous outpouring of interest on the business community. Part of it seemed to be helpful that it was in a limited community. It is in Denver. They were able to negotiate the packages. But they are preparing to take this statewide now, because it has been so positive. That is one model.

ASSEMBLYMAN McGREEVEY: And it is a managed health care model also, isn't it?

MS. LOPES: Yes. The acute care facility is the public hospital, but it is also their tertiary center connected with the University of Colorado.

ASSEMBLYMAN McGREEVEY: So then it is similar to the Allied Signal, I mean, they have a provider network which includes a number of hospitals, a number of physicians? In addition to that, on the expanded program, Maureen, will they control the size of the employer who is eligible for the SCOPE Program?

MS. LOPES: I believe that is controlled at 25 or under, if I remember correctly. What is interesting about this is, they did not stipulate that you-- You could already have insurance and still get into this. Other programs say you have to have been without insurance for a year, usually.

Just to give you a sense of it, they calculated there were 90,000 adults in Denver without insurance. I will go back and talk about how this relates to some of the lessons that seem to be across-the-board.

In Maine there is the most state involvement. There are significant dollars there. Just as a background: Maine is one of those states that gets a 70/30 match on Medicaid, so it is a very low-income state. There they contracted with a commercial HMO to provide the managed care. Employees receive the subsidy for their portion of the premium payments if they are at 200% or below poverty. So the subsidy in this case is going to the employee, paying their portion of the premiums.

There is also reinsurance again, which seems to be a very popular thing. I think it was $15,000 in Maine, so the HMO, if the claims went above $15,000, could tap into a state fund. They have only had one claim against it in a year, which is interesting. It was a prenatal -- a premature birth.

Then, a third model, if you didn't see the article in The Wall Street Journal last week, talking about what Virginia, Washington, and Florida have done to tackle this problem-- They removed the mandated benefits in Virginia and Washington. So I see that as another model attacking the cost thing.

Some of the lessons learned, very quickly: It was possible to develop an attractive, lower-cost product that some portion of the small business market would jump at. None of these programs have gone on long enough so that we know where they bottom out, you know. I see this as a (indiscernible) effect; that you have Medicaid. We may do Medicaid expansion. If we can bring in a good chunk of the small business community, we would have done a good job there. We don't know what size group we are left with then, and that is what a lot of these projects are supposed to tell us. What is the hard core? My guess is that it would always be difficult for small businesses with a very high turnover, or a very young work force. I mean, if mostly you have 18-year-olds in your business who want the wages, who don't want the health insurance, and are the least likely to be -- except for motorcycle accidents, or something -- in the health care system-- They may never want to be in it. It may not make any sense either.

I was very encouraged by the positive response there was to a variety of plans. None of these plans look exactly alike, but they are all getting a positive response.

The other lesson, though, was that without subsidies, you probably wouldn't penetrate very far. So they talked about three different types of subsidies. You could buy down the

premium, like they are doing in Maine. You could do tax credits. Or this reinsurance idea. Evidently, Massachusetts is doing it by issuing a bond issue. That is the way they are putting together that reinsurance pool.

We did have almost ready to go live a proposal here in New Jersey to use reinsurance, and that was put on hold pending the Commission's results. But that seemed to be a very hopeful thing to do. I think in New Jersey we thought it would be down around the $5000 level; that the stop loss would be at that level.

Thirdly, there have probably been a lot of myths or changing experiences in the small business market; that insurers have been very reluctant to get down there. But when they do enter the market -- and places like Denver and Arizona have also had this experience -- they are not getting a particularly different pattern of claims experience than the bigger companies. We were speculating on what has changed. Think about what has happened in the economy over the last 10 to 15 years. We used to be very much industrialized, a big portion of the work force in the large companies, and just a lot of small ones. Well, we have been downsizing the big companies. People have been taking an early retirement and going off and starting new businesses. So now the small business employee group mirrors more closely what used to be the big group -- the big group of employees. So they are not disproportionately skewed one way or the other.

Denver found that actually most of the employees they were picking up were 35-year-old males in good health; that they weren't a higher risk group. So I think this information is very important for the insurance companies also, and they are trying to decide where to set premiums for this group; that we are getting sort of an evening out across this country of who is working where.

I also think mostly it is just stories you hear. I agree that it is true that benefits are a major reason that people choose to work one place or the other. So I think employers try to do that if they can. After finding it is very expensive, I think the first things that are going are, wages are being held down, and then maybe you are laying off your part-time people, and only then do you touch benefits, because that is more sensitive than wages these days; that you will lose your prime people if you just decide to cut out insurance.

I think if we can overall do something within the Governor's Commission to help to hold down cost increases and take care of that side of it, people will stay in the market and they will get into the market with some of these other reforms.

ASSEMBLYMAN McGREEVEY: It is interesting that The New York Times had an editorial back in 1989 that talked about the Washington plan, as well as the proposed Colorado plan. The interesting thing -- and there are some analogies -- is that basically, as I understand it, if you look at Washington, for example, they have a population of 17.4% of all state residents who are uninsured. Fifty-five percent of the uninsured are either full- or part-time, and the other 37% are children. The only difference that I saw is what they tried to do in the formation of their basic health plan -- and as you noted it was in a demostration area-- It was basically for people under 65 who do not qualify for Medicare and have a gross income under -- which does not exceed 200% of the Federal poverty level.

They basically exempted -- as did, I understand, Virginia and Florida -- this bare boned, small group policy from state mandates to cover certain medical treatments. What they did cover was hospital care, lab tests, x-rays, and emergency care. What they also did was cover preventive care such as immunization and routine checks. The only thing on the Washington program was, it cost the State of Washington a

substantial amount of dollars. The figures I have from OLS are: The plan operating costs for the next two years for the Washington basic health plan will total $47 million; $39.9 million for benefits, $2.7 million for administration; with a $4.4 million reserve. Those costs will be offset by $6.2 million in anticipated premium revenues and $1.2 million in interest. But the difference is going to be carried by legislative appropriation of $27.2 million for the 1989-1991 biennium, and $12.3 million for a carry-forward provision for the previous biennium budget.

So the point of the matter is, when you talk about especially the Washington program, which utilized a sliding scale to determine family size and income, one of the concerns about that basic health plan was the size of the expenditure by the state legislature to provide for basic health care. That is why the Denver program looks attractive, because the Denver program did not require--

MS. LOPES: There is a whole range, too, depending on how deeply--

ASSEMBLYMAN McGREEVEY: Sure.

MS. LOPES: I mean, my personal philosophy is that you move fairly cautiously in these things, see who you can pick up for the least dollars, and keep ratcheting it down. It is very hard for us to predict otherwise. If we could really model, you know, that this additional marginal dollar is going to pick up this many, we would know what to do, but I think it is hard to predict. That is why also I would lean toward something like Denver.

ASSEMBLYMAN McGREEVEY: One of the concerns I have, one of the potential problems with the Denver program or the Washington program, is that -- and this is cited in one of The New York Times editorials -- does it give employers incentives to drop insurance now offered to low-income workers to ratchet down?

MS. LOPES: Oh, to drop down to that minimum package? Well, I think that is a very important question. If, as policy, we could decide here that there is a basic plan that does meet the needs of people, then why would our concern be that someone did drop down to that level? I mean, if we had our best medical evidence that what we want in there is immunization, or 10 different things--

As a society we have said, "This is what we mean by a right to health care," because we haven't really defined that. I don't see where there is a major problem with people dropping to that level. You know, maybe you have to do that in bad times, until the economy picks up again. That has always been a key labor issue, negotiating additional pieces into the health benefit package. So, these things moderate over time, too. But at least if people are getting the basics-- I would rather see them get that than a few people getting a Cadillac plan. I guess that is just a trade-off that I would be willing to make.

ASSEMBLYMAN McGREEVEY: Well, what do you say in the face of this increase about add-on costs that we are presently experiencing in the uncompensated-- How are you going to address those costs, through a voluntary program? I mean, there would still be those who would not accept the voluntary program, so how do you pay for uncompensated care then?

MS. LOPES: That gets back to the earlier question. I think, you know, I would just, at this point, say that we are definitely supporting something broad-based. We have to get it off of the hospital premiums and the hospital bills. I know exactly what that means. That is a three-letter word. (laughter)

ASSEMBLYMAN McGREEVEY: Would it be possible to offer, in terms of-- You know, ideally, this should be a national program, I think. In the absence of that, wouldn't it be best to say that all New Jerseyans should have a modicum level of

health care insurance, and that in addition to requirements of, say for example, a decent level of universal coverage, that that be required? In addition to that, why can't we also work programs similar to Massachusetts, whereby you have a managed health care program that is offered on a statewide basis? Why couldn't you do both, in the sense of requiring a threshold level of decent coverage -- universal coverage -- and concurrent with that, provide a system, say for example, similar--

MS. LOPES: To provide that coverage.

ASSEMBLYMAN McGREEVEY: Yeah, to provide that coverage, whether it is managed care for Medicaid patients like the Garden State Plan, or whether it is utilizing some of the philosophies that Allied Signal is using in terms of the private sector, the point being, without the first, without requiring an acceptable decent level of health care insurance or coverage, you will still have significant gaps in those who choose to step forward to the plate.

I am not saying that you should have one without the other. Obviously, we should move toward looking at a health care network such as Allied Signal posited, but there you have a company that is responsible, a company that realizes the decency argument. Why can't you do both?

MS. LOPES: I don't see those things happening simultaneously. I think maybe that is where our disagreement is. I think all of those things have to be in place; that the reforms in the small business market have to take place, that there are provider networks out there that people can buy into, and allow the voluntary market to do the best it can at that point. Then if you are left with a significant number of people who are not anteing up, you know you have done your very best. I just don't think that policy-wise New Jersey has yet tried those steps.

I think it is interesting that other states have also been concerned about mandating it before, or at the same time, of doing something innovative. I would rather do the innovative, get the costs down, and then see who we are left with.

ASSEMBLYMAN McGREEVEY: So you're saying the reasons why the--

MS. LOPES: I don't think we are going to be left with a very big pool. I guess that is my level of confidence.

ASSEMBLYMAN McGREEVEY: So then you are suggesting that the reason why this type of health care plan hasn't been offered originally, is because of the present range of broad health care that has to be offered under State insurance policy?

MS. LOPES: I think mandated benefits has added to it; that it--

ASSEMBLYMAN McGREEVEY: My question is, if this is going to be so profitable, why hasn't it already been done?

MS. LOPES: It seems to me that the lessons learned from these demonstration projects were missed -- at least that is a term that was used yesterday -- or there were misconceptions, or the world had changed in the last 10 years; that the small business market can be profitable. Whereas the assumption up-front was that it wasn't, and that someone had to step forward, like the Foundation, and prove that times have changed. I think that has been demonstrated.

ASSEMBLYMAN McGREEVEY: Okay. Nick?

ASSEMBLYMAN FELICE: Thank you. It is interesting, in listening to this last phase of it-- Many years ago, the brilliant legislators, or the Legislature, both houses, decided that New Jersey needed -- or, mandated that everyone in New Jersey should have auto insurance, and we ended up with a figure of about 800,000 people riding around today without auto insurance. It ended up with the JUA.

We're talking about mandating a health program for all businesses. We're starting in the opposite direction. We have about 800,000 people who are working who do not have any health care. I agree with you. I think there is a lesson to be learned here, mandating programs that cannot be enforced and don't work, where you have people looking for an out. I think the direction that some of the states have taken, from the media, and from talking to some of these states--

The incentive has to be there. By that I do not mean we are going to dangle the golden watch in front of all small businesses, but I really believe, in the field I am in and in talking with businesses, that small business would like nothing better as an incentive to keep good employees to continue their business, than to provide a minimum health care package.

I think that part of the problem, in reading internationally about other countries that have national health care programs and socialized medicine-- Part of the problem, of course, is that we have to specify what minimum health care coverage is actually going to be required; how much of it is going to be utilized, and how much of it today is overutilizing the hospitals and health care programs.

I think people themselves, if they knew that they had even basic coverage, whether it be for automobile insurance, liability for their homes-- The big question is, some kind of basic coverage for health care. I think that is the direction we have to go, without saying, "You must have all these programs." A lot of the health care programs, when they start getting into some of the benefits like the dental plan, glasses, and every other thing-- A lot of these programs really end up-- The employers and the employees ended up paying for the Cadillac options of these programs.

We have to be very careful. Watching what is happening in other states, we have now health care rationing. So now we are getting to the other extreme, where we are

mandating programs. The next think you know, we will be rationing how much of that health care that is mandated that we can give out.

I would just like to say that somehow the direction we are going is, yes -- without mandating all the features -- certainly one that we should look into. I think that is the only way we are going to get some kind of a report of how it is working in other states.

ASSEMBLYMAN McGREEVEY: Thanks, Nick. I appreciate your candor today, Maureen. Frankly, I think there is room for both at the table. We have to provide a basic health care plan that provides for health care coverage to uninsured individuals and families at an affordable rate, and we have to make that basic health care affordable to uninsured citizens. But, in addition to that, we also have to provide certain specific "incentives" to make sure they come to the table.

Thank you for your testimony.

MS. LOPES: Thank you.

ASSEMBLYMAN McGREEVEY: We don't want your good company to be picking up the whole tab for--

MS. LOPES: We appreciate your concern.

ASSEMBLYMAN McGREEVEY: At this time, I would like to call upon Ira Stern, from the ILGWU, Chairman of the Health Care Committee.

I R A S T E R N: Thank you, Mr. Chairman and members of the Committee, for this opportunity to share the New Jersey Citizen Action-- I am here on behalf of New Jersey Citizen Action's Health Care Committee. My other affiliation is with the International Ladies Garment Workers Union. I am here to share New Jersey Citizen Action's views on this important subject.

I am Ira Stern, and I Chair New Jersey Citizen Action's Health Care Committee. I am also the Political and Educational Director for the New Jersey Region of the

International Ladies Garment Workers Union. With me at my right is Carlton Levine, New Jersey Citizen Action's Health Care Organizer.

New Jersey Citizen Action is the State's largest citizens' coalition, with over 90,000 member families and more than 65 affiliated organizations. The organizations with Citizen Action represent labor, community, senior citizen, tenant, environmental, and religious groups. The ILGWU is one of those affiliates.

Currently there is a tremendous variation between health care benefits provided to the employees of different companies. Due to the high cost of insurance coverage, many plans are inadequate and many workers are left without any insurance at all. For small businesses the costs often prohibit any coverage, not to mention the complete lack of coverage for the many unemployed and self-employed individuals.

In my own union,-- I am veering off of my prepared text right now -- the ILGWU, unfortunately we have had to limit health care coverage for three main reasons: 1) the ever-increasing cost of health care; 2) most of our members work for small employers which cannot absorb huge increases in costs; and 3) due to a lack of work in our domestic industry, our members are unemployed for longer periods of time than they used to be. Therefore, during these periods of unemployment, no moneys flow into the health care funds from which they normally would receive benefits.

New Jersey Citizen Action believes that the only way to provide affordable and proper coverage for all our State's residents, is to take a universal and comprehensive approach. Clearly, the greatest efficiencies can only be achieved through programs that use a single-payer model. The type of planning and approved access that is part of a single-payer plan pays off in more ways than just saving money. Prior to establishing their National Health System which works on a single-payer

plan, Canada's health care indicators were worse than those of the United States. Since their plan has been introduced, Canada's health care indicators have improved much faster than -- and have surpassed -- those in the United States.

Clearly, our current system needs drastic repair. Insurance now covers only 74% of the cost of physician services, 39% of dental costs, and 25% of prescription drug bills. Seventeen percent of Americans with serious illnesses such as cancer, heart disease, or diabetes did not see a doctor in 1986. Until we assure all of our State's residents equal access to health care without regard to ability to pay, these problems will persist.

We can provide comprehensive coverage with the same or even lower health care expenditues. By adopting a single-payer approach we can significantly reduce the waste and inefficiencies of our system.

According to a study published in the New England Journal of Medicine -- February 13, 1986 -- "Overall, 23 cents of every health care dollar in the U.S. goes for billing and bureaucracy, as compared to 13% in Canada," and, "Only 88 cents of every private health insurance dollar went for care, the rest stayed with the insurance company. In contrast, the Canadian provincial insurance plans ran an overhead of less than 3%, as did Medicare and Medicaid in the U.S."

There are many other examples that could be named. However, what is most important is despite spending more per capita than any other nation, we have far from the best health care in the world. The only way to properly provide health care to our residents is through the rational planning that is an important component of single-payer systems. New Jersey Citizen Action believes that we can no longer afford to try piecemeal approaches that may not reduce, or even control costs. More than a dozen states are considering universal health care proposals. We urge this Commission to adopt a

universal comprehensive health care program for New Jersey that is based on a single-payer model.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. In terms of your proposal, Mr. Stern, how would it be administered, and who would it be administered through?

MR. STERN: It would be administered through the State, or through the government, or through, you know, a source that the government deemed within an agency of the government. That is what we would hope for.

ASSEMBLYMAN McGREEVEY: Who would pay for it, and how would the services be provided?

MR. STERN: You ask, "Who would pay for it?" I am asked this question quite frequently about who, you know, would pay for a national health -- a universal comprehensive approach to health care. Right now, we are paying a great deal of money as it is for health care.

ASSEMBLYMAN McGREEVEY: No, no, I am not debating. I am just asking, what would be the financing mechanism?

MR. STERN: It would have to be a broad-based tax.

ASSEMBLYMAN McGREEVEY: You would do a broad-based tax as opposed to an employer or in terms of an employee contribution, or--

MR. STERN: Well, it could be-- I say a "broad-based tax." It could be an employee paying a certain percentage, the employer paying a certain percentage, much the way we do-- It would follow the methods and the ways we are financing Social Security and Medicare right now; you know, employee and employer contributions.

ASSEMBLYMAN McGREEVEY: Okay. Nick?

ASSEMBLYMAN FELICE: Basically, looking at many of the unions and the people involved, when you have, say, in the garment industry, seasonal workers who work six, seven months and are then off, are those workers covered when they are in-between?

MR. STERN: Correct.

ASSEMBLYMAN FELICE: They are? Okay.

MR. STERN: This is where the change I mentioned has come about, for the most part. Our policy has been, when members fell out of work, up until recently-- Up until just a couple of years ago, our policy has been that as long as a member was looking for work, they would be covered for up to six months while they were unemployed. What happened was, many workers were unemployed for two or three months a year, sometimes less, sometimes a little bit more, but our coverage always continued. It didn't stop, whereas most employer plans, or negotiated plans stop usually after 30 days after an employee leaves the employer. We had that model because we realized the seasonal nature of our industry. But as a result of the fact that we were losing-- We were losing membership, but even those members we did have were working less and less per year due to a number of factors, one of which being, you know, the problem of imports and the problems the domestic industry is facing.

So we have had to limit the amount of time that people can be on coverage. What we tried to do was-- The only way we came up with was to have an earnings test. Unfortunately, this was the way we had to go. If an employer earned so much per year last year, or so much in the previous three months, they would be covered for the next three months. That is to say that so much went into the health care fund so that that coverage could continue. That is where we are now. Unfortunately, our members have to pass an earnings test to collect -- to continue to collect benefits for up to six months.

ASSEMBLYMAN FELICE: That is exactly those employees, of course, who are actively looking for work, whether they are here or anywhere. They certainly are collecting Unemployment Insurance, too, aren't they?

MR. STERN: Yes.

ASSEMBLYMAN FELICE: Okay. See, this is a perfect example of what we talked about. It seemed so unrealistic many years ago, people who were unemployed collecting -- collecting Unemployment Insurance -- that a small portion of that be taken out to give them some kind of a minimum coverage while they were not working. As you say, the periods are getting longer and longer. At one time, it was two or three months during the seasonal change of the industry, but now, as you know, it is sometimes four, five, or six months. This is quite a strain on both the employer and, of course, on State funding.

Thank you very much.

ASSEMBLYMAN McGREEVEY: I just want to hear your reaction to the idea that I think Maureen Lopes put forward for New Jersey Business & Industry, the concept of for those who are uninsured presently, some type of bare bones health insurance policy on an experimental limited coverage nature -- for those who do not offer health care benefits.

MR. STERN: Those employers which do not have health care insurance to have a bare bones policy mandated, or--

ASSEMBLYMAN McGREEVEY: Well, no. She obviously didn't say that, but in terms of providing -- to provide it to lessen the present coverage that is now required under the State of New Jersey insurance regulation.

MR. STERN: We are not in favor of lessening coverage to anybody.

ASSEMBLYMAN McGREEVEY: Well, no, this would be for people who do not have any coverage now.

MR. STERN: Right now, the problem is--

ASSEMBLYMAN McGREEVEY: I mean, the same way you have a means test. There's got to be a balance, for those who have no--

MR. STERN: Yeah, right. We are working within the current system, as far as we can work, in ideality, I am talking about. I think many people believe there has to be a

fundamental change in the way we are providing insurance to people. Health care is not something that should be available only to the rich. Then we are talking about mandating a low-level policy for those who are unemployed, or who do not have employers who give that policy. We still do not feel that is adequate. Many of the low-level policies I heard talked about-- One person mentioned allowing them to use the hospitals. That is a high-cost solution to an obviously simple problem.

We are looking for ways to reduce the costs. We think there is an enormous amount of waste; there is an enormous amount of money that goes into administration.

ASSEMBLYMAN McGREEVEY: But we are not discussing-- I mean--

C A R L T O N L E V I N E: I would say, in response to a bare bones policy, as Ira started to indicate, the problem with that is it would focus health care on the most expensive sources--

ASSEMBLYMAN McGREEVEY: Acute care.

MR. LEVINE: --of health care. It is just not--

ASSEMBLYMAN McGREEVEY: But you could design it so it didn't. Other states have designed it so that-- Actually, some states have designed it so it is primarily preventative. I mean, it is a matter of how you design the program.

MR. LEVINE: Well, that would definitely have to be a very important part of the program, but it would seem to us-- We believe you would really have to take a much more comprehensive approach to the health care issue, in order to control costs throughout the system, and to make it available to everybody in the manner that is required by all citizens of the State of New Jersey.

MR. STERN: I think a mandated minimum benefits type of plan would be an intermediate step before we get to where we finally have to go in the long run, and that, hopefully sooner than later, is toward national universal coverage.

ASSEMBLYMAN McGREEVEY: Thank you very much.

John Ronches, Vice President, Industrial Union Council.

J O H N R O N C H E S: Good morning.

ASSEMBLYMAN McGREEVEY: Good morning.

MR. RONCHES: My name is John Ronches. I am the Associate Director of the Committee of Interns and Residents, which is the union which represents salaried physicians in New York and New Jersey. Today I am appearing on behalf of the New Jersey Industrial Union Council, which is a federation of labor organizations in New Jersey which represent more than 200,000 members.

What I have presented this morning, Mr. Chairman, is the Industrial Union Council's policy statement on health care in New Jersey. If you will excuse me, I will not read the entire report. I have left it with you, but let me highlight the important aspects of it.

We suggest two significant changes in our approach to delivering health care in New Jersey, and we think they are inseparable. The first is, we must expand access. We must include those people who now do not have insurance coverage, and we must find some way to control the costs of providing that. We don't think we can, at any point, begin to add a significant number of people to those who are provided coverage, without, in some way, dealing with the costs.

I heard you make mention earlier to the Massachusetts program. I am not intimately familiar with it, but my understanding of the chief problem with the Massachusetts plan was that it dealt with an employer-based program that didn't include everyone, and there were not sufficient cost mechanisms in it.

We would suggest that we expand on the current system, which is that most insured persons in New Jersey get their insurance coverage through their place of employment. And we would suggest that that is the foundation for expanding

coverage. We would require that all employers be required to provide some level of coverage. The phrase "basic benefits" has been tossed around, and it is somewhat of an amorphous concept. It is certainly a matter that, if we get to the point of negotiating over what the specific basic benefits are, we will be almost there.

We think that all employers should have to provide benefits, and we think the State should provide a similar package of benefits to those who are uninsured or out of the work force. We would suggest for small employers who perhaps may not be able to find insurance in the marketplace, that we could structure a plan much in the way we do now for our Temporary Disability Insurance, where employers would be free either to purchase insurance in the marketplace or contribute to a State plan which, in turn, would provide the benefits.

What goes along with this, as I mentioned earlier, is some way of controlling the costs. You know all the statistics on where costs have gone and where they are going. We suggest that the only way to deal with this is by what was referred to by our previous witness, Ira Stern, as a "single-payer system." If we don't find a way to put all of our resources into one place and then find some way to direct them out of that one place, then we will continue to have what we have, which is that rates are set by providers, except for hospital rates in this State. Providers just set rates. There is no negotiation, and the pressures on rates will just continue. We won't see any change in what we have seen over the last 10 years.

So we, too, suggest a single-payer system. You will see in our statement that we have talked somewhat about how to finance that. There are three pieces: One is that there is a significant degree of current funds spent on health care in New Jersey. Some of those are direct, and some are indirect. There would be, obviously, some new funds required. You will

see that our statement refers to a surtax on unemployment contributions. I should just tell you that that piece of it is somewhat under review, and it may be necessary, depending on the figures, to make that somewhat more broad-based.

The last piece, which I think is as important as all of the others, is savings. A single-payer system produces savings in administration, which cannot be achieved in any other way. We envision that in a single-payer system, rates with providers would be negotiated ultimately. Perhaps there would rate-setting initially, but ultimately rates with providers would be negotiated, with appropriate allocations for -- or adjustments for specific concerns. But we think this would restrain the costs of growth. I think people who talk about savings in providing health care benefits, whether or not we expand access, are fooling themselves. We may have long-term savings here, but there is nothing we are going to do today that is going to save us money tomorrow.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. Just a few questions: You are proposing something similar to Governor Cuomo's Unicare Proposal?

MR. RONCHES: I haven't seen Governor Cuomo associate himself with that exactly, but--

ASSEMBLYMAN McGREEVEY: Well, he mentioned it in his State of the State Address. I'm sure he doesn't want credit for it. But in terms of where the State would be the service provider?

MR. RONCHES: Well, not the service provider.

ASSEMBLYMAN McGREEVEY: Excuse me, may be negotiated with the service provider for the--

MR. RONCHES: Yes. The Unicare Proposal envisions two roles for the single payer. One is the negotiator, or the rate-setter.

ASSEMBLYMAN McGREEVEY: The rate-setter.

MR. RONCHES: And the other is effectively to be a major purchaser of health care insurance; in fact, either the state Health Department or some agency, as we do for Medicaid, for example, or Medicare, would be retained to be the single source of claims payments.

ASSEMBLYMAN McGREEVEY: So, in addition to requiring a basic benefits package for all-- You would require a basic benefits package for all employees?

MR. RONCHES: Yes.

ASSEMBLYMAN McGREEVEY: And then, subsequent to that, you would create, in a sense, a universal health care insurance policy?

MR. RONCHES: That's right.

ASSEMBLYMAN McGREEVEY: Where the State would serve as the negotiator, or as the contractor, if you will, with the service provider?

MR. RONCHES: That is correct.

ASSEMBLYMAN McGREEVEY: How would that work in terms of the fiscal mechanism?

MR. RONCHES: Well, I think-- My union represents physicians, but they are salaried physicians, and we don't often have discussions within my organization about that. I think we would have to include in that discussion some of the providers and have direct discussions about how that would best be set up. It might be done on a regional basis. It might be done on a county basis. It might be appropriate to-- We have had some experience with this in setting DRG rates for hospitals, and we have some ideas about things that work and things that don't work. I think we could take that experience and use it for negotiating rates with other providers.

ASSEMBLYMAN McGREEVEY: What would be the system so that employers would pay into a specific fund that would be administered by the State and, in turn, all employees would be guaranteed the basic health care benefits?

MR. RONCHES: Well, we suggest that either employers will provide the benefits, or that they will pay into the State's plan, again as we do for a number of disability insurances, and the State would then provide the benefits.

ASSEMBLYMAN McGREEVEY: So, the individual employer would have the option of providing these benefits to his own managed health care program or indemnity program, or paying into the State-administered program?

MR. RONCHES: That's right.

ASSEMBLYMAN McGREEVEY: When you talked about basic benefits, you mentioned the difficulty in ascertaining what are appropriate benefits. How would you-- I mean, is there a State program you would recommend? The second question is: In terms of catastrophic coverage for citizens, could you address the question of how we would provide catastrophic health care coverage under that basic benefit plan?

MR. RONCHES: Well, that is part of the reason we didn't specifically define the basic benefits. You will see that there is some commentary on comprehensive coverage which we think needs to -- I'm sorry, catastrophic coverage which needs to go along with it. I think as you move toward this-- Frankly, I am not a health care economist. I am not familiar enough with the figures to know where you cut the lines. Two hundred percent of the poverty level is a standard that I have heard used not infrequently.

So, I don't know exactly where you would draw the lines. I mean, there are some things that are obvious to us. Inpatient hospital care certainly is a necessity, and should be covered in any basic plan. I would suggest -- and you will see it in our policy statement-- We talk about emphasizing maternal and child well care. The problem with the system we have now, is that we pay for sickness. We don't pay for health. What we need to do is shift some of our resources to-- One of the earlier witnesses was talking about those

things that keep people out of the hospitals and out of the more expensive settings for delivering care.

I don't know exactly where you draw that line. I suspect we have as many opinions about that as we have people in the room, but I am sure there is a line that could be drawn that would be a sensible one.

ASSEMBLYMAN McGREEVEY: Mr. Ronches, concerning those who still would not be covered by your proposal, namely those who are either indigent or who, for whatever reason, do not qualify -- do not participate in the Medicaid Program, or the State health care plan, how would you fund the Uncompensated Health Care Trust Fund?

MR. RONCHES: In our suggestion we contemplate that the State plan would, in addition, provide for those people who are out of the work force, or who are uninsured. Those who are employed and uninsured, we talked about earlier. In addition, those who are out of the work force and who are not eligible for Medicaid would be covered through the State plan.

I mentioned earlier that we made reference to funding that through an unemployment surtax, but again I would just take a step back from that today. It may not be the most appropriate way to do it.

ASSEMBLYMAN McGREEVEY: Okay. But in terms of funding for those -- the working who are unemployed presently, you would fund that through--

MR. RONCHES: That is what I was referring to with the unemployment surtax.

ASSEMBLYMAN McGREEVEY: Yeah, exactly.

MR. RONCHES: It may be more appropriate to do that through a broader based tax.

ASSEMBLYMAN McGREEVEY: Okay, thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: I caught part of it. I went to warm up with a cup of coffee. I think they could use this for a cold storage building today. It has been a little cool.

The problem here is, this is very idealistic, to have all of these features, but the bottom line, again-- It's great. I think we in New Jersey have been leaders in many programs such as uncompensated care. But to have all of these things, somewhere, someone has to be able to put out the money. This is almost saying, "Well, it is a form of socialized medicine." Everyone naturally is entitled to health care regardless of their economic or employment status, but the bottom line is, how do we pay for it?

MR. RONCHES: I suggest that we are paying for it now; that for those people who are uninsured, we wait until they get sick enough to get admitted to a hospital, and we pay for it through the Uncompensated Care Trust Fund. How we would pay for this is the wrong question. How can we afford not to have it?

ASSEMBLYMAN FELICE: You're right. I should rephrase my question: How do we do it so that a small group of people are not paying for all? That is the question maybe I should have asked you, because it is not a fair way, an equitable way of health care payment, and I think that applies to many other things. But that is what I am really asking.

MR. RONCHES: In our proposal, the Uncompensated Care Fund would be eliminated. There wouldn't be a need for it anymore. Everyone would be provided with health coverage in one manner or another, mostly through their employment. But, in any event, there would be no more Uncompensated Care Fund.

Another one of the advantages in that system would be that all of the providers would be assured then of a pretty stable funding source, and could predict both their costs and their income over a longer period of time. But we are going to pay for it one way or another.

The other thing we don't do now is, we don't control costs. We control hospital costs, but we don't do it with any of the other costs.

ASSEMBLYMAN FELICE: So, really, it is almost a State or a national health care type of a program we're looking at, because, you know, we said when we went to the JUA, we could eliminate the high risk auto insurance program we had, and it turned out that we are paying for a lot more people than we expected the program to handle. Here, too, you say, "Yes, we are paying for it now, but the question is, how equally is the cost shared?" And I think that is really what we are looking at here today. It's there. Someone has to pay for it. Fortunately, in New Jersey, we do have the Uncompensated Care, so that those people are getting care whether they can afford it or not, but the question is: How do we keep the costs down so that very few are not paying for all?

MR. RONCHES: Well, there are two elements there. One is, you are talking about uncompensated care, which is assessed on a limited group, as opposed to having the costs spread over a much larger group. The other is how you control those costs. In the end, we are not controlling them now.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much, Mr. Ronches.

At this time-- Is Barbara McConnell here? (affirmative response from audience) Hi, Barbara.

B A R B A R A W. M c C O N N E L L: Shall I go ahead?

ASSEMBLYMAN McGREEVEY: Yes.

MS. McCONNELL: Okay, thank you, Mr. Chairman. I have submitted testimony. I guess it has been passed out to you. I am going to just highlight my testimony, because I have with me Bill Dixon, who is Manager of Corporate Compensation and Benefits for Wakefern Food Corporation, and I would like to conserve some of the time I might use to allow him to share with you some of his company's policies and views.

In looking at our State's health care delivery system, the New Jersey Food Council starts with the following two premises:

1) It is unacceptable for any citizen to be denied quality health care because they cannot afford it, or because they lack health insurance; and

2) The premise that health care in New Jersey and across the nation is unacceptably high, and is rising at unacceptably rapid rates.

We agree that both of these problems must be addressed, but we also believe it is inescapable that the access-to-care problem is a function of the cost problem. Therefore, we strongly urge this Committee, as well as the Governor's Commission, to look at the flaws in the existing delivery insurance system which have brought us to this place.

There are a number of areas which would seem to offer opportunities for meaningful cost controls. Ideas for study include -- and many of these have already been pointed out by other speakers this morning, certainly in the business community-- Studies should include reform of medical malpractice laws, which now encourage unnecessary procedures; perhaps an expansion of coverage in Medicaid; and reform of insurance underwriting practices for businesses and individuals to permit small businesses and individuals to purchase coverage at reasonable rates.

The rising costs of new technologies and alleged hospital over-bedding is another area that continues to need a look at; perhaps expansion of certificates of need for doctors' offices as well as clinics; and, of course, a continued and aggressive effort by all segments of New Jersey's society toward prevention and wellness.

But the essential cost control issue that is most critical to our industry is the trend toward mandatory health care costs to employers. It is here that I am not going to read my testimony, because many of the facts and statistics I have in there have been brought to your attention and can be made a part of the record. But I think there is strong

evidence, as we look across the country at what has happened in other states that have enacted mandatory costs-- We have seen that health insurance rises. In Maryland, for instance, a state with 32 such mandates in its law, a study shows that these provisions increase the cost of coverage by 12%.

Another study by the National Center for Policy Analysis estimates that 25% of the 37 million people in this country not now covered by health insurance, probably would be insured were employers not scared away by the expansive, or expensive mandated benefit provisions in some state laws.

The irony of the situation is that employers who provide health insurance are then subject to regulations as to what specific benefits they must provide. On the other hand, employers who offer no health insurance are not going to be affected by mandated benefits.

Moreover, the cost of mandated insurance coverage would severely impact segments of our economy, especially the small business and retail sectors. And of course, from the New Jersey Food Council's perspective, the most significant impact would be on the food distribution industry. To understand this impact, it is necessary to review the economics and demographics of our industry. And if you will bear with me for just a moment, I will give you some of those demographics:

Food retailers, wholesalers, and manufacturers currently employ approximately 200,000 people in New Jersey. This represents one of the largest segments of the work force and one of the fastest growing. Since 1980, our industry has created close to one million new jobs nationally.

Last year, American's spent $329 billion in grocery stores. Total food sales, including restaurants, were $413 billion. In other words, as a nation we spent $100 billion less for food than we did for health care. Additionally, Americans spent only 11.7% of disposable income on food compared to 13.6% in 1980; again, a marked contrast to the

health care industry. There are, of course, many differences between food distribution and health care, but perhaps the most striking difference is in the competitive nature of the respective industries. Food retailing is a highly competitive industry. Health care is not.

Food distributrors voluntarily offer a wide variety of benefits in order to attract and retain a productive, dedicated, and loyal work force. In 1987, our industry conducted a comprehensive survey of benefits offered to our employees. Responses were received from companies, both large and small, many of which are located in New Jersey.

The survey showed that almost all respondents -- 97% -- offer health insurance to their full-time workers. These coverages are, on the whole, comprehensive, generous, and expensive. A new survey is currently being conducted, and I will be happy to share the results of this with this Commission. In addition, I am doing a survey among New Jersey Food Council members on a number of health related questions, including coverage -- types of coverage -- as well as seeking opinions on some of the solutions that are facing your Commission today.

In the food retailing business, approximately two-thirds of our work force are part-time. This reflects the nature of our business. The typical supermarket is open over 100 hours a week; many are 24-hour operations. Our industry has always attracted large numbers of young people, students, and others interested in part-time work to supplement their own income from another job, or those of their parents or spouses.

The 1987 industry survey showed that 61% of these part-timers were under the age of 21; 89% were under 25. The turnover ratio for part-timers was over 70%. In other words, two-thirds of these employees in our industry are no longer working for the company one year after hire.

Keep in mind that these are generally lower-paying, entry-level positions. An employee earning the new minimum wage of $3.80, and working 20 hours a week for 50 weeks, will earn $3800 a year. According to the 1987 survey, the average cost of coverage in New Jersey stores, per employee -- for health coverage -- was over $3200. That ranges from $3200 to $4200 per employee. Thus, the cost of employing a minimum wage part-timer would go up by over 50% if health insurance had to be provided to all part-time workers.

The typical supermarket being built today employs over 100 part-timers. The average supermarket, including the older, smaller stores currently being phased out, employs approximately 50 part-timers. Assuming the relatively low average of $2000 cost for insurance for each of those employees, the average cost per store would be $100,000. For new stores, the cost would be over $200,000.

It is well-known that the food distribution industry operates on the tightest of margains. Only 1% of every dollar received is profit. Therefore, in order to absorb $100,000 in increased costs, a store would have to generate increased sales of $10 million. Food prices would go up. Wage rates would be stabilized, if not reduced. Many other employee benefits would be cut, and many jobs would be eliminated. It would no longer be possible for food retailers to hire many of these individuals on the margin of the work force.

Please understand that many of our part-time workers are covered by health insurance. These statistics are brought to your attention simply to show the large number of part-timers in our industry and that, generally speaking, if there were legislation that mandated that all part-time workers be covered, these would be some of the results.

At this time, I would like to introduce Bill Dixon, who is with the Wakefern Food Corporation, one of the largest employers in the State of New Jersey, to share with you some of

his thoughts, and also programs of the Wakefern Food Corporation.

I would be happy to answer any questions. Thank you.

W I L L I A M D I X O N: I would like to thank the Commission for the opportunity to testify on matters relating to health care insurance coverages. In particular, I would like to comment as a benefits administrator who is trying to deal with the realities of providing health care protection to our full-time employees, and yet maintain some sort of handle on costs that are increasing at alarming rates.

As independent companies, and even as a organization, the New Jersey Food Council, we have not been able to effectively deal with controlling the high costs of providing our current level of health benefits. These costs have severe effects on all industries, all employers, and all residents in the State of New Jersey. Hopefully, this legislative Commission, based on its recommendations, can provide some equitable and workable solutions to the problem.

Wakefern Food Corporation, the company I represent and a member of the New Jersey Food Council, is a cooperative supplier and merchandising organization supplying 33 companies, both private and public, trading under the Shoprite supermarket name. As a cooperative, we are the largest in the nation. As a combined entity, our 33 Shoprite members have over 35,000 employees in New Jersey.

Our member companies have the majority of their employees in a multitude of unionized bargaining units and provide benefits through a variety of health and welfare plans and private insurance contracts.

Wakefern, as an entity within itself, employs about 3000 full-time associates, half of which are covered under benefit programs negotiated through collective bargaining agreements. The other half of our full-time employees are covered under nonunion company plans.

As you are undoubtedly aware, health insurance coverage has become the premier point of contention in collective bargaining settlements over the last several years, only because of costs. My primary responsibility has been for the non-bargaining unit benefit programs within Wakefern.

The problems encountered in administering these programs are reflective of the bargaining unit programs in our industry and of health care programs, both union and nonunion, in all industries; namely, trying to provide health care and protection against financial hardship to our full-time employees while coping with the spiraling costs.

We provide our full-time associates with a comprehensive medical insurance program including: hospitalization, x-ray, lab, major medical, prescription drugs, dental, and even vision, completely company paid, including the employees' dependents.

Although costs are the main factor, we are also concerned about employees -- just diverting from my statement for a few moments. We recently instituted a substance abuse program. When we did that, we noted that a standard feature in our Blue Cross hospitalization particularly excluded hospitalization for drug addiction, and we modified our program to include that, thinking, you know, that it was the right thing to do.

Last year, in our budgeting process, while trying to maintain conservative increases in our operating budgets in order to remain competitive, a 40% increase in hospitalization premiums caused alarming concern. With our health care costs increasing at about a million dollars a year for the 1500 nonunion people, we made an in-depth study of the benefits we provide and the costs.

Over the course of the last several years, there have been numerous programs by agencies and marketed by insurance companies and consultants under the guise of cost containment:

DRGs, HMOs, PPOs, second surgical opinions, preadminission reviews, flex plans, the whole gambit. Many health plan administrators have been stampeded into doing "something," in the hopes of controlling costs, but most of these programs have had little, if any, success.

An example was a major thrust several years ago to direct a number of medical procedures to the less expensive outpatient setting. As hospital administrators trying to cope with their own budget deficits identified this trend, many outpatient procedures became more expensive than the inpatient procedures.

The "Medical Benefits Digest" issued a report indicating the components of a 21.5% health care inflation rate for 1989. Thirty percent of the additional costs was due to government cost shifting to the private sector already.

At a time when many companies are already reducing benefit coverages, any additional costs that would be incurred as a result of additional utilization due to mandatory coverages, particularly on part-time employees, would be an undue burden on the business community. In my company, such mandatory coverage could severely jeopardize the coverage we currently provide to our full-time employees and their families, simply on the basis of economic feasibility. In summary, the main obstacle in providing any additional mandatory coverage is the uncontrolled cost increases for the current coverages we provide.

In my industry, we can see a consumer drive two miles down the road to another supermarket to save five cents on a can of corn. But yet, when it comes to medical care, most people don't question their doctors on price, and if they do and they find one doctor who will do an appendectomy for $5000 and another for $6000, many would think the $6000 doctor must be better, and would have him or her do it since the insurance is going to pay for it. Perhaps one suggestion would be to

mandate that all providers of medical services post their fee schedules. This may provide incentives for competition, make the patient a better consumer, and perhaps lower prices.

I thank this Commission for the opportunity to address it, and I would be happy to provide any information or assistance in the future possible. Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Dixon, and thank you, Ms. McConnell, for your presentations.

One of the things that we have concerns about, though-- I agree with you: You don't want duplicative coverage, obviously, for part-time employees, recognizing the profit margin the industry works under. What do you say to the point that if someone isn't providing-- Obviously, for those who are under 18 or 21, frequently they are under their family plan, etc., and that would probably be the preferable option. But what do you do in the case of, say, someone who is not under a family plan, who is independent, unaffiliated with a familial relationship, to provide for insurance coverage, and they go into the hospital and don't have adequate means of paying for health care coverage? Who pays for them?

MR. DIXON: Well, it may be a very simplified situation. Somebody has to pay for them. They have to be cared for. Is it right to put that on the private employer? I don't know, considering the costs they are faced with now. Is it the responsibility of the State or Federal government to take care of those people and provide a safety net? It probably is. How do you pay for it? It is going to cost "X" number of dollars. I am not an economist trying to figure that out. But it comes to the simple fact: Yourself, myself and my personal finances, or my company, when we deal with operating budgets dealing with the company. There are certain things that have to take priorities.

The State of New Jersey has billions of dollars in revenue; has billions of dollars in expenses; has thousands of

items. Somewhere, a priority has to be looked at in terms of: Where does this fall in terms of expenditures? Off the top of my head, not even thinking, and having nothing against, say the Garden State Arts Center-- That just happened to pop up when you were mentioning where the funds were going to come from. It may be self-sufficient, for all I know, in terms of reality.

But suppose, for example, the State is providing $2 million to that facility.

ASSEMBLYMAN McGREEVEY: So you're saying that basically it comes out of general revenue funds and it has to be a higher priority?

MR. DIXON: If it is providing that $2 million, is that a priority compared to providing health benefits to a group of people not covered? Those are hard decisions that have to be made.

MS. McCONNELL: I would like to follow up on that: While I agree in part, I think when we look at the whole uncompensated care issue, I think what we first have to do is look carefully at who are not covered and what we can do to begin to bring some of those people under health coverage. And I think one of the areas -- and this has been brought out before, and I am sure you are aware of it, Assemblymen -- is the whole area of small business. I think we have to do something to change the system whereby small businesses can obtain coverage for their limited number of employees at a reasonable cost. I think that is number one.

Number two, I think when you look at the statistics of who are not covered, we are finding a lot in the whole poverty area below the poverty range. What can we do to get those people employed and under some kind of health coverage system? But to be more specific from our industry's perspective -- and this has not been cleared by the Board -- we are paying now for uncompensated care through increased premiums of insurance.

ASSEMBLYMAN McGREEVEY: Of course.

MS. McCONNELL: Somebody's got to pay, whether it's general revenues or whether it is some sort of broad-based financial program. I would say to you that our position would be that it's got to be more broad-based. You cannot continue to penalize those employers who are providing health coverage for their employees by paying for those who are not. So, some equitable system has to be worked out, whether it is out of general revenues -- and we all eventually pay for that -- or whether it is some three-letter-word system where we pay on a more equitable broad-based basis.

ASSEMBLYMAN McGREEVEY: I agree with your statement that we have to work very arduously to develop some type of basic health care plan that is affordable for small businesses.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Yes, thank you. Two-thirds of your employees, evidently, are part-time, according to your report. Do you have any coverage at all for any part-time employees?

MS. McCONNELL: Yes.

ASSEMBLYMAN FELICE: You do. And what is the standard? How many hours does that part-time employee have to work?

MS. McCONNELL: Perhaps Bill can answer that better than I, but it is my understanding that it depends on the time of service -- term of service. We have a lot of part-time workers who have been with companies for a number of years. Also, statistics show that a large majority of our part-time workers are no longer with that company one year after having begun. But, yes, there is health coverage for part-time employees. It is mostly union negotiated. Am I correct, Bill?

MR. DIXON: Right.

MS. McCONNELL: Would you speak to that, please?

MR. DIXON: There are a variety of unions; there are probably at least a half a dozen unions in New Jersey that

part-timers would fall under. One recent settlement in terms of part-time insurance coverage-- There was minimum coverage after a year of service and a thousand hours. Again, because of the cost of benefits, in the most recent settlement -- about two months ago -- part-time benefits would be available after two years of service and completion of a thousand hours in the second year.

ASSEMBLYMAN FELICE: It is a minimum coverage basically, right?

MR. DIXON: Only on the individual, no family.

ASSEMBLYMAN FELICE: Right, and there is no co-pay at all? Is there a co-pay with that?

MR. DIXON: Honestly, I don't know.

ASSEMBLYMAN FELICE: It is an interesting fact, you know, that--

MR. DIXON: Most of the plans have a 20% co-pay. I don't know about that specific settlement.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. Our next guest will be Mr. Milton Fein, who is speaking on behalf of himself. Mr. Fein?

M I L T O N F E I N: Thank you. Good afternoon, Mr. Chairman. I was very much interested in reading in this morning's Star-Ledger that a particular bill was signed yesterday -- Assembly Bill No. 3101. It seemed to have flown right through. That Assembly Bill No. 3101 was one regarding potential health care problems. It was a bill written on an individual person named Tishna Rollo, an eight-year-old victim suffering from some particular rare case of cancer. I was impressed with how a bill went right through, was passed in the Assembly, and was signed. Therefore, I think your Committee can do things and get certain things done within the next few months, not waiting years and years. I have heard vested people with their own interests asking your Committee not to move and not to do things as rapidly as possible.

To give you some input, I was going over three questions. Let me give you an answer to question number two, about the difficulties encountered in obtaining coverage and recommendations for improving health care insurance from a practical individual point of view. An individual is working for a company for 10 years. In 1988, his wife becomes ill, and his medical insurance pays the entire tab. This is in August of 1988. In December of '88, he is terminated from his company, along with about eight other people. He obtains the COBRA coverage, not for two years, as the other gentleman has said, but only for a maximum of 18 months. One little hint: If he files for a legal separation or a divorce from his wife who is ill, she can obtain the coverage for 36 months. That is if he goes through that additional step, which people would not normally do.

So now he has coverage for 18 months. He pays the full tab himself, plus an additional 2% administrative fee to his ex-employer. The insurance company takes care of the entire tab. I am talking about several hundred thousand dollars worth of medical bills. Unfortunately, I think the people in the Assembly are not people who are knowledgeable with what happens to that person. His S.S. number is on file with the insurance company. It goes to various other services where insurance companies exchange data with one another. In essence, that person who is ill, through no fault of his or her own, whose insurance company has now paid the bill-- That number is listed and you are uninsurable.

Now the person who is out of work several months gets a job with a small company -- eight or ten people. After 90 days with that company, he applies for the insurance. It is a company called John Alden. An application is filled out. It is filled out honestly. He puts down his wife's illness, because should there be a need for coverage, it will come out in the end. You are not going to put down that you never had

this and you never had that. The insurance was denied. They do not want to cover the wife and, therefore, did not want to cover him.

So, this person continued the COBRA plan, paying the full tab each month himself. He got another job with a company in Rahway, New Jersey, a company with approximately 80 employees, insured with Blue Cross/Blue Shield of the State of New Jersey. What the people in your Assembly do not understand is the word that seems to be in each insurance book. It is listed under the category "Preexisting Conditions Waiting Period." So now you are insured under COBRA, and your bills are being paid. You are now in a new job, and after 30, 60, or 90 days you are eligible for coverage under Blue Cross/Blue Shield, except here, your wife and yourself, who have not had medical bills other than your wife's illness, are not covered from 12 months to 24 months. What good is getting and paying the tab for the new insurance you have from the new employer, when they are saying, "We are going to cover you, but not for the preexisting condition"?

What I am looking at is the one thing that I think your Committee can do. If this particular bill -- Assembly Bill No. 3101 -- which was put through at that time by Mr. Michael Adubato and others, covering certain additional treatments that were excluded from pamphlets such as this from different insurance companies in the State of New Jersey-- I am sure the insurance companies lobbied very heavily that this bill not be passed, because it would mean additional monetary expenditures out of their pockets. Nevertheless, this bill was passed. That means that anyone now needing that particular treatment, which was previously excluded-- It will now be part and parcel, whether it is printed in here or not-- It will be a benefit they will be able to get.

I would like to see you eliminate this preexisting condition from all insurance in the State of New Jersey.

Therefore, the Milton Feins, whose wife or child has been ill, who separates from his company voluntarily or, in my case, involuntarily, has his COBRA insurance. The 18 months ends on June 8, 1990. He has a new job. He is covered under Blue Cross/Blue Shield, but his wife's prior condition--

To give you an example, chemotherapy treatments at the Robert Wood Johnson Hospital in New Brunswick, two nights, Thursday night and Friday night, with checkout Saturday morning-- Do you have any idea what the treatments run under your DRG bill? Thirty-seven-hundred to $4000. That is on actual charges of $1760. That $1760 is jacked up to close to $4000, based on the payer factor, price per case, under whatever the DRG category for the individual is. To me, that is a rip-off. I am being ripped off every time I have to pay the 20% differential, as I have paid in the past on my share, which was up to $5000. After $5000, that 20%, which is $1000 co-pay, my insurance company, previously the COBRA company, then paid the full 100%.

But it just shows you that the-- You know, I am using this as a guide. When someone gets a driver's license in New Jersey, I assume it is not a right, it is a privilege to get your license. Your license can be taken away; it can be revoked. You have to meet certain-- Who gives these damned insurance companies the right to put in their policies "preexisting conditions"? "No benefits will be provided for the first 'blank' months after the effective date of coverage." Who allows them to exclude -- to include that provision? In my case, the only thing I would need from this insurance company on the new job are the benefits for my wife, because the benefits of the COBRA plan for 18 months have terminated.

As well as putting through this bill -- and I am sure the insurance companies did not agree to pay the additional benefits for a rare form of cancer where she needed a bone

marrow transplant -- you could have just as well said to the insurance companies, "We are going to exclude any policy that gets a new employee who gets hired whose company has Blue Cross/Blue Shield, Guardian, or any other company that is licensed to do business in New Jersey--" "You will not have a preexisting clause in your policy," and they will have to eat it, because they still want to do business in New Jersey. They are just looking to be excluded from the -- how shall I say it? They don't want to touch that patient with the preexisting condition with a 10-foot pole, because they know outright that it is going to cost them bucks; more bucks than they are taking in in premiums.

I would like to see this as one of the first priorities of your Commission, to eliminate the preexisting condition on every single insurance policy for a new person like myself joinging a company, waiting the 90 days, getting coverage--

To give you one further example, this company in Rahway has 85 or 90 employees. When I checked, only 35 or 37 of them were covered. I couldn't understand why men with families, women by themselves with children-- The premium -- and this is a group that fell in the category of a certain 14 to 49 of eligible people-- The premium was 590-some-odd dollars. The reason I looked at this was, on my first paycheck stub, when I became eligible, I looked and saw there were 290-some-odd dollars deducted. I thought possibly-- When I took 290 times 52, it came out to roughly $3400 a year. When I was paying my full premium to my old employer under COBRA, it was $300 a month for hospitalization, major medical, prescription, dental, the whole ball of wax. Here, under Blue Cross/Blue Shield of New Jersey, my employer was paying 290-some-odd dollars -- 50% -- and out of my paycheck was being deducted the other $590 times 52, which is approximately a little bit under $6000 a year.

Blue Cross/Blue Shield is supposed to be, I thought, a so-called nonprofit blank, blank-- You know, I checked. Of all the insurance companies in the State of New Jersey, the executives of Blue Cross/Blue Shield make the highest incomes, from the Chairman to all the Vice Presidents and so forth. They might be nonprofit, but they are sure ripping off the people of the State of New Jersey, as well as these companies. If I have to pay the 290, the owner of the company has to pay the same 290 for each employee. The word, "ripoff" is putting it mildly, when they have the highest paid staff of executives compared to the private insurance companies. Something should be investigated in their operation.

ASSEMBLYMAN McGREEVEY: Thank you very much, Mr. Fein. Personal statements have a way of making the reality of this situation all the more apparent.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Having been through a situation such as yours, I can really sympathize and understand what you're saying. Naturally, the insurance companies or anything else that is considered a high risk-- Possibly something in the direction of those who have never had any coverage going to an insurance plan with a definite high risk illness, is one thing they would cover, but possibly something to the effect that those people who were covered under a health care plan and because of circumstances the plan was terminated and you went to the other effect of paying on your own, those people who were under an existing plan when they contracted a serious illness-- Maybe there should be something considered to allow those people not being the ones to be excluded when they reenter a plan. I think you have a very valid situation.

MR. FEIN: To give you an example, what about the person starting out from college, starting out from 1959 -- from 1959 to 1988 and up-- I'll say a few hundred dollars worth of medical bills. What about all the years of paying

premiums, both myself and my employers, without utilizing the system; then in 1988 some catastrophic illness hits, and now you become uninsurable?

You know, I have a daughter who teaches at the Elizabeth High School. She has been there for about four years. When you teach in a school system and you are under whatever the pension plan is-- Just say she now gets a job closer to home in Bridgewater or Franklin Township or Somerset. Her pension stays with her within the system. There should be something whereby when you are covered and you now have this illness, and you now get another job and you have to wait a certain period of time-- You could pay your own money, pay your own way under COBRA. That is what it was intended for.

But I don't think that Senator Bradley or any one of the people in the Federal government, when they enacted the COBRA law, said, "Fine, 18 months. That sounds like a reasonable length of time. An individual leaves his job, has medical expenses, we'll give him 18 months to pay his own tab. He can be insured until he gets his new coverage." They never counted on, when you got the new coverage, the words "preexisting condition" would be printed in one of these books. Now you get the new coverage, and everything is hunky-dory if you don't have any medical expenses. But your S.S. number is on file somewhere as having a prior condition, and now you are covered under the new coverage, but you are not covered for that preexisting condition.

That is where that so-called safety net-- It does have a loophole; it doesn't exist right there.

ASSEMBLYMAN FELICE: Mr. Fein, I think you have a legitimate input into this Commission in what you're saying. I think the definition of "preexisting condition" has to be one whereby: 1) Was that person under a health care plan when he or she contracted the serious illness? 2) Was that person never in a health plan and is now coming into a health plan,

never having been either employed or actually in a preexisting health policy? I think there is the type of consideration we have to give it. I think you have a legitimate--

MR. FEIN: Am I correct in saying that if that Assembly bill regarding the bone marrow-- Did it not go through in a relatively fast manner? It went through, probably, with no opposition because it wasn't a partisan issue. It had nothing to do with being a Republican or a Democrat or an Independent. It was for the good of a young child and for other people who might need that particular medical care. I would think that the elimination of a preexisting condition could go through within the next six months, or by the beginning of next year when your Assembly meets full-time. That, I think, would be one of the major things your Commission could do.

Thank you.

ASSEMBLYMAN FELICE: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you for coming, Mr. Fein.

At this time, I would like to call upon Mr. John Dalton, Healthcare Financial Management Association.

J O H N J. D A L T O N: Thank you, Assemblyman McGreevey. We are novices at this, so I submitted both our position paper on financing uncompensated care and my testimony which has been condensed from that position paper.

I am John Dalton. I am currently the immediate past President of the Healthcare Financial Management Association's New Jersey Chapter. HFMA is the nation's leading personal membership association for financial professionals involved in health care. We have roughly 27,000 members around the country, and the New Jersey Chapter has 800 members. Chapter members volunteer their time and the Chapter has no paid staff. We have spent considerable time studying the uncompensated care issue, and we appreciate this opportunity to present our conclusions to the Assembly Health Care Policy Study Commission.

Thirteen years ago, your legislative colleagues made a commitment that all New Jersey residents would have equal access to health care delivery, regardless of their ability to pay. That legislation has placed our State in a position that is unique within this country. In its 1987 study of access to health care in the United States, the Robert Wood Johnson Foundation concluded that New Jersey led the nation in providing equal access to health care services, and I quote:

"The poor, minorities, and those lacking health insurance have significantly better access to health care in New Jersey than do low-income and uninsured persons in the nation as a whole."

Princeton University's world-renowned health economist, Uwe Reinhardt, refers to our health care delivery system in New Jersey as: "Health care with a soul," and describes New Jersey as, "a civilized nation, not just a place to live." I think that is something that we all, as residents and citizens, should be proud of.

Fostering equal access has created other problems, as you are all well aware. The original legislation provided that such costs would be financed by patients who have insurance. This placed our inner-city hospitals, which have the highest uncompensated care burdens, at a competitive disadvantage. Their rates became significantly higher than the rates at neighboring suburban hospitals due to the shifting of the significant costs of care provided to the medically indigent patients they serve.

In 1986, the Uncompensated Care Trust Fund enabled these costs to be shared statewide. It became the vehicle for collecting funds from hospitals that had lower levels of uncompensated care and disbursing the funds to hospitals that had higher levels of uncompensated care.

That financing mechanism worked reasonably well while Medicare was picking up its fair share of statewide

uncompensated care costs. However, that changed dramatically January 1, 1989 when Medicare stopped contributing its fair share. Since Medicare beneficiaries comprise roughly 45% of the inpatients in our hospitals at any point in time, a significant amount of uncompensated care costs then had to be shifted to other insured patients and self-pay patients.

This shift is mandatory under New Jersey's rate-setting system. Hospital revenue bases are controlled in total by the Department of Health and the Hospital Rate Setting Commission. In other states those costs are shifted to charge base payers where they are unregulated. We are different here in New Jersey. So this is the cost shift that triggered the huge increases in health insurance premiums and complaints from employers who pay those premiums, which you have heard about on several occasions.

What causes uncompensated care? Really two factors:

1) Patients who are unemployed or marginally employed, but not eligible for Medicaid. These we frequently refer to as those "unable to pay" and the cost of their care often is written off to charity care under the State's guidelines.

2) Patients who are fully or partly employed, but uninsured. These are the ones we end up calling "unwilling to pay," and their costs of care often get written off to bad debt. So, bad debt, plus charity care, are uncompensated care costs.

The situation is not always black and white. Why are uncompensated care costs increasing? Costs are estimated to have increased from $366 million in 1986 to an estimated $650 million in 1990. Stated another way, such costs appear to have increased from 6.1% of hospital revenues in 1986 to an estimated 10.5% in 1990. That percentage of revenues is the way a normal business would measure bad debts to sales.

In HFMA's analyses, the primary cause of the cost increases has been the shortfall created when the Medicare Program withdrew on January 1, 1989. When uncompensated care costs are adjusted to give effect to that Medicare shortfall, it is clear that uncompensated care costs as a percentage of hospital revenues peaked in 1987, and have been declining since. There is an exhibit which I have attached to my statement based on data from the Department of Health that clearly illustrates that. As you can see, the heavy dark shade is what uncompensated care costs would be if we pulled Medicare out of the equation, and they have been declining.

They were at 5.9% of revenues in 1989, which compares very favorably with nationally published data throughout the health care industry. So we are doing at least an average, or maybe better than average job in New Jersey in controlling those costs.

Shifting the Medicare shortfall to other-- The apparent increases are primarily attributable to the Medicare shortfall, so what we have here is really a Medicare funding problem, not a hospital operations problem or a Trust Fund administration problem. It is Medicare that is the culprit. Shifting that Medicare shortfall to the other insurance carriers is the primary cause of the increases in health insurance premiums, and these increases have fallen most heavily on the New Jersey businesses that provide health insurance coverage to their employees. It is both ironic and unfair that those who provide coverage are forced to shoulder the biggest part of the uncompensated care burden. Conversely, businesses that provide little, or no health insurance coverage to their employees are exempt from the uncompensated care burden that their employees may generate.

The HFMA has made seven recommendations. First, we urge that the funding mechanism for uncompensated care be broadened so that the burden is shared more equitably, and we have two recommendations here:

1) Taxes on alcohol and tobacco should be increased significantly. Research has shown that both tobacco and alcohol contribute to health problems. Significant amounts of uncompensated care costs are incurred by patients admitted to hospitals' substance abuse programs, so why not tax it at the source?

2) A payroll tax should be imposed on all employers to finance the balance of uncompensated care costs. Conceptually, the tax should function on an "as needed" basis in a manner similar to the Unemployment Compensation Tax, i.e., employers who provide health benefits would receive a credit against their tax, while those that do not provide health benefits would be fully taxed. This broader funding mechanism would spread uncompensated care costs across a more appropriate base.

Next, to reduce the costs of uncompensated care to New Jersey taxpayers, HFMA has two other recommendations:

1) Medicaid eligibility criteria should be expanded to the federally allowed maximum. This would both increase the number of New Jersey residents who are eligible for Medicaid and reduce the uncompensated care burden financed by New Jersey taxpayers. Since the Federal government contributes 50 cents of every Medicaid dollar, this would increase the flow of Federal funds for health care into New Jersey, and help correct our negative "balance of trade" with the Federal government.

2) Permit potential Medicaid recipients to be qualified at hospital sites. This would initiate the Medicaid eligibility determination process in a timely manner and would relieve hospitals from their current burden of having to coax the patient, or the patient's guarantor, to visit the local welfare office in person, face to face, to complete that screening process. Conceptually, this recommendation is similar to the program that New York City has used quite effectively in its hospitals for several years. Such measures would benefit providers, the public, and the State.

Our final recommendations are more mechanical and are directed at keeping the costs of compliance with the Uncompensated Care Trust Fund regulations in line with the benefits obtained.

Compliance with pre-service and post-discharge procedures mandated by sections 9 and 10 of the present Act is proving to be extremely costly. Anecdotal evidence to date suggests that the benefits obtained are minimal. The estimated annual costs of compliance with sections 9 and 10 are $25.5 million a year statewide.

The present Act treats all patient types the same. In other words, regardless of whether you are an inpatient, a same-day surgery patient, a clinic patient coming back time and again, a referred ambulatory outpatient coming for a test, or an emergency visit, you are treated the same. The present regulations say you've got to do the same steps on all of those types of patients. They do permit a more limited set of post-discharge procedures to be followed when due-from-patient balances are less than $200. Post-discharge procedures are what we call "follow-up and collection procedures." However, in all instances, the identical set of pre-service procedures are mandated; in other words, the procedures that relate to registration, insurance verification, and financial screening.

These requirements are enforced by retrospective audits of bad debt and charity care accounts. Hospitals are finding that they need to invest in additional staff, space, and equipment in order to minimize their exposure to these retrospective audit penalties. Unfortunately, these cost increases do not appear to be producing significant benefits; i.e., we are not seeing increased cash collections in excess of the expenses that hospitals are incurring. HFMA recommends changes to the Act and the regulations whereby:

1) Patients registered in and discharged from the emergency room would be exempted from the pre-service

requirements relating to Medicaid referrals and charity care screening.

2) A more limited set of post-discharge procedures would be permitted for patients with due-from-patient balances or self-pay balances under $500, rather than the $200 at present.

3) The Uncompensated Care Trust Fund Act should be modified to permit more flexibility in tailoring the credit and collection procedures to each hospital's needs, rather than mandating a standard set that each must follow.

Acute care hospitals are required by their license to provide emergency room services. Patients arriving at emergency rooms usually are not prepared to answer an extensive list of questions about assets and financial resources. In fact, data compiled last year in a Trenton hospital's emergency room indicated that fully 40% of the patients arriving in that emergency room had no identification whatever available at the time of their visit. So exempting such patients from the two audit criteria would help make it easier for hospitals to attain the required 70% audit compliance level on their outpatient accounts.

Permitting more limited post-discharge procedures for due-from-patient balances under $500 would reduce the aggregate hospital costs incurred for compliance, would move the largest volumes of accounts through the process more efficiently, and would bring third-party intervention to bear sooner.

Unfortunately, consumers are less likely to pay bills for health care services than they are to pay rent, utility, and installment charge bills. After all, failure to pay the rent bill could lead to eviction. If we don't pay our installment charge bill, somebody might come and repossess our TV or our VCR. But medical treatment once given, cannot be taken back. It takes third-party intervention and a threat to an individual's credit rating to get the medical bill paid, if

it is going to be paid. Studies indicate that the likelihood of collection diminishes rapidly as due-from-patient balances age, so moving unresolved due-from-patient balances more quickly to a collection agency should be encouraged.

Finally, if the Uncompensated Care Trust Fund Act permitted a bit more flexibility in evaluating the cost-effectiveness of collection procedures performed, rather than mandating a prescribed set of procedures, we think the law's cost-effectiveness would be greatly enhanced and that this would result in lower health care costs to all of those who pay for health care services. The Act was a good start, but it needs some fine-tuning.

The conclusion basically summarizes what I said before, so rather than go through that, I would be prepared to answer any questions you might have. I would like to thank you for your time.

ASSEMBLYMAN McGREEVEY: John, thank you for your comments, especially those regarding collection procedures. I think you set forth some very worthwhile recommendations.

Going back to the onset of your testimony, you noted, obviously, that patients who are fully or partly employed but are uninsured are unwilling to pay. Differentiating for a second the Medicare, the cost shift -- the cost shift both in terms of the DRG and also in terms of the Federal government's unwillingness to compensate for the indigent health care-- From the statistics we see, approximately 69% of those who are uninsured are working -- are employees or the dependents of employees. Narrowly -- and I am sure you have subjected yourselves to the pros and cons and travails of both positions-- Narrowly, as to the question of addressing that 69% of that 877,000, or what seems to be a moving target of uninsured, and mindful of the fact that I understand what you're saying in terms of a payroll tax on all employers, how would you bring more employers to the table to provide health care insurance?

MR. DALTON: I think it is going to take something like a payroll tax to do that. You are not going to get all of them there voluntarily. Speaking personally, I set up a small business myself almost four years ago, and until such time as I had sufficient employees to form a group, I was giving my employees an allowance each month so they could, in some cases, continue their COBRA coverage, and in some cases purchase coverage.

I have to tell you flat out that some of those employees elected to spend the allowance and not provide the coverage. Other employees in the same instance did not do the same kind of thing. I think you've got to provide some kind of an incentive. The negative -- the punitive side of it is that they will tax you if you don't contribute, but if you do cover your employees you will get credit against that tax. I think that kind of an incentive will work quite effectively, particularly with the smaller businesses throughout the State.

I did find a lot of the prior testimony rather interesting. I certainly envy the task you've got in synthesizing it. There are a lot of various facets you've got to consider.

ASSEMBLYMAN McGREEVEY: Now say, for example, you would set forth that a payroll tax should be imposed upon all employers, and that a credit would be given to those who do not provide for health care benefits. Do those moneys just pay for the Uncompensated Health Care Trust Fund and keep things going as they are now, or do we create a diffferent financial fiduciary relationship between the State and the service providers?

MR. DALTON: Our inclination would be to continue the Trust Fund because it has been a good mechanism for collecting and disbursing, but to dedicate those revenues from the payroll tax to the Trust Fund -- to financing the Trust Fund. Unfortunately, Governor Florio has already usurped a good piece

of the tobacco and alcohol taxes, but since we are faced with a budget surplus in the next couple of years, I would kind of suggest that we take whatever he is going to get from those taxes and dedicate it to the Trust Fund.

ASSEMBLYMAN McGREEVEY: I think we ought to call Doug Berman. (laughter) So basically you would say-- One of the concerns we have -- and I have seen this proposal before -- is, what stops an individual employer from recognizing-- What stops the movement toward increasing the cost of the uncompensated-- I mean, you say you would provide a punitive measure if they don't--

MR. DALTON: Yeah. They will pay the tax if they are not providing health benefits to their employees. Under your normal State payroll tax audit which you do for unemployment purposes, you would also pick up this element of it and work out a credit mechanism. I don't profess to be an expert on that particular aspect of our recommendations. One of our other members worked it up rather in detail. But I think that mechanism provides you both the clout and the incentive needed to get them to the table.

ASSEMBLYMAN McGREEVEY: I would just be curious to see what you think the payroll revenue enhancement measures should be in terms of how much it should cost and what the realtionship is between that cost and the actual types of services, or the actual dollars worth of services that would be provided by virtue of that tax.

MR. DALTON: Our rough cut estimates-- Again, these are not-- We didn't go through a lot of econometric modeling to try to get these numbers, but it seems to us that to provide coverage for the employee, we are talking about numbers on the order of $1500 per year in the norm, so the payroll tax would be on that kind of order.

Our proposal did not contemplate providing full coverage to employee dependents, because I think if you get

the 840,000 uninsured picked up, you won't have that problem. What you have currently are a lot of major employers picking up benefits for spouses, some of them employed by small employers who do not provide benefits.

ASSEMBLYMAN McGREEVEY: Mr. Dalton, what do you say to the argument, in a sense, that by having this type of payroll tax that you are, in a sense, creating a health insurance policy -- or health insurance program de facto by requiring a payroll tax in the amount of "X" dollars, but you have none of the attributes of managing how those health care dollars are being spent, e.g., preventative medicine, preventative health care, etc.?

MR. DALTON: That is an issue that you really need to deliberate. I have heard much about the bare bones insurance plans, and--

ASSEMBLYMAN McGREEVEY: Or the Allied program in terms of a managed-- I mean, if we are going to expend the dollars, let's expend them as prudently as possible.

MR. DALTON: That is more of a decision that you are going to have to wrestle with as legislators. There are a lot of pros to the Allied program. We are familiar with what Allied Signal is doing, and it does appear that they have gotten a handle on the amorphous mass of the employers' health care costs.

In terms of the Uncompensated Care Trust Fund, regulating the costs incurred by the hospitals, the audit procedures are pretty effective. In my own company, we work with a lot of hospitals around the State in attempting to attain compliance. I can tell you flat out that they are working very, very diligently just to try to maintain their current levels of compliance. These are fairly stringent procedures, and they are much more stringent than what we see carried out in other states. So we do have somewhat of a model here in New Jersey, in terms of how these things take place.

ASSEMBLYMAN McGREEVEY: The bottom line is that you are recognizing, or you are supporting the concept that all employers have to be part of addressing the need for health care coverage?

MR. DALTON: Yes.

ASSEMBLYMAN McGREEVEY: Whether through a tax or whether through an acquired management plan, etc.

MR. DALTON: Yeah. Let's face it, we made a societal decision 13 years ago, and it was probably a damned good decision, that we would provide a very good financing mechanism. Unless we are going to rescind that societal decision we made 13 years ago, then it makes sense to bring everybody into the boat, and this would seem to be, probably, the nuts and bolts that seem to be the most practical way to do that.

ASSEMBLYMAN McGREEVEY: Okay, thank you. Assemblyman Felice?

ASSEMBLYMAN FELICE: Just briefly, I notice we made some reference to the pre-service procedures at the hospitals. I don't know if you realize it, but there has been legislation through both houses -- and I don't know if it has been signed into law yet -- changing that procedure.

MR. DALTON: Yes, that was Assemblyman Otlowski's bill. It is currently on the Governor's desk awaiting signature.

ASSEMBLYMAN FELICE: Right. That would help that procedure a little bit.

MR. DALTON: That bill will help on part of the pre-service procedures. It will provide some good relief in response to that recommendation we have made.

ASSEMBLYMAN FELICE: And I agree that the eligibility criteria for Medicaid would certainly expedite health -- the overall costs of getting those switched over from Medicare to Medicaid in a more timely fashion.

Thank you.

MR. DALTON: Yes. On the on-site interviews, particularly at our Newark/Paterson/Camden/Trenton hospitals would be a real plus.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much for your time.

Laura Giannotta?

L A U R A G I A N N O T T A: Hi. I am Laura Giannotta, from the National Federation of Independent Business. Just by way of background, we are an umbrella business association representing about 600,000 small and independent business owners nationwide. NFIB members employ seven million workers in this country, generally about 10 persons per member. In New Jersey our membership stands at about 9000.

I would like to first point out that I don't believe that people in New Jersey are being denied access to health care or to health insurance. The State's Uncompensated Care Trust Fund and the Blue Cross/Blue Shield Company have assured the availability of hospital care and the availability of insurance.

The problem is not access; it is 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 $2100 in 1988 to $2600 in '89. They estimate that by the end of this year, that premium will be $3200. These national figures are supported by a recent survey of our members here in New Jersey. Ninety-seven percent this year reported insurance cost increases over the last year. Thirty percent of those responding to a poll experienced increases of 20%, while more than half of those responding to this 1990 poll saw their insurance premiums double.

Also in this poll we found that about 76% of our members provide health insurance, so I don't think you can say

that it is small business that is the culprit here. The climate here in New Jersey does not encourage small businesses, or any businesses for that matter that cannot self-insure, to provide health insurance. There are a couple of other reasons why health insurance is not offered or purchased on an individual basis.

In New Jersey, it is not a deterrent. If you don't have health insurance, you can still go to the hospital. They won't turn you away. So what is the value of having a health insurance policy? It is only of value to those who which 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, much like we experience with auto insurance.

Another reason many New Jersey residents go without insurance coverage or employers do not provide it, is that State statutes and regulations prevent the purchase of policies that are tailored to the individual or the family need.

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, which was February of 1988, there were 868 mandated benefit laws affecting every state in the country. The enormous increases in health insurance costs can be tied to the proliferation of these mandates.

Surveys indicate that the overriding issue for determining health care offerings by small employers is profitability. I have not heard any discussion so far about how small businesses, if they are just starting out, if they are not operating in the black -- how they are going to either pay this tax, or provide health insurance. These things have to be looked at.

Small business needs flexibility in determining what benefits it offers and its negotiation process with its employees. They should be provided the same options that larger companies' self-insured programs have, and that is the exemption from State mandated benefit laws. They also need a more stable and predictable marketplace that guarantees not only the availability, but the affordability of health insurance.

One of my members called me, oh, about two weeks ago just to report in on his latest Blue Cross/Blue Shield bill. In '88, it was $5000 for eight employees. This past June, a quarterly premium was $11,000. Now, I don't know what his history is with his employees, whether they have a large claim, but they are in a high risk occupation. How do you predict increases like that? You really can't plan for that, and in any business you have to be able to plan for it.

So we see that there is a product there that can be purchased. The problem is, how do you come up with the money to pay for it? I think what we have to do is overhaul the whole system. There should be a reinsurance mechanism, and there should be a change in the rating of small group policies to help to alleviate the problem of affordability.

This reinsurance mechanism and a change in rating would guarantee coverage to all groups, and that could even include groups with high risk individuals. It would also provide a more predictable and stable pricing structure.

I have included in my testimony several other laws adopted in other states; several other proposals that are being considered. One I believe Maureen from Business & Industry mentioned, the Multiple Employer Trust, which seems to be working in North Carolina. A program recently enacted in Connecticut which takes into account a reinsurance mechanism and rating changes-- I believe that was just signed earlier this year. I think that is something that should be looked at, to make health insurance more affordable.

There is also some information in there on an Oregon plan which provides tax incentives to encourage small businesses to provide health insurance. There are a number of different approaches that have been discussed, and are being implemented across the country. I think probably New Jersey's answer is a combination of these. The legislative response to this problem should not serve to restrict the private sector with further mandates, however. The public and private sectors now have the opportunity to develop an innovative and comprehensive solution to the problem, and NFIB and its members look forward to working with you on that.

ASSEMBLYMAN FELICE: Thank you very much. I think the onus -- a lot of it -- was on small businesses having a problem with supplying any kind of a health care package that is really affordable. But I think it should be noted that there are many large companies which have co-payment programs where the employees are not even working on a co-payment basis.

We hear the most, actually, from some of the new companies and the smaller companies because of the percentages that are incurred with small businesses with the small amount of employees. I think the question is not availability; it is a question of affordability. That is the thing we are also trying to address.

I appreciate some of the input we have gotten, especially about some of the programs that have taken place in other states. I thank you for your input. We really appreciate the suggestions you are making, too.

MS. GIANNOTTA: Something I didn't mention: The Uncompensated Care Trust Fund Advisory Board had a Task Force on-- It was to come up with programs to encourage small businesses to provide health insurance. We did come up with two plans to encourage small business to provide insurance and to reduce the uncompensated care debt. Those have been put on hold until the Governor's Commission reports back, but these

are copies of the two proposals, if you would like to take a look at them as well.

ASSEMBLYMAN FELICE: We would. Thank you very much.

Our next witness will be Sylvia Contessa. Sylvia, if you would, please.

S Y L V I A C O N T E S S A: Thank you. Good afternoon. I know it has been a long day, and I thank you for the opportunity to speak here today.

I am Sylvia Contessa from Community Health Care of North Jersey, Inc., a certified home health agency that provides nursing, physical therapy, occupational therapy, and speech therapy in the home setting. I am here today, really, to testify on behalf of the New Jersey State Nurses Association to provide general information about access to care, not merely on cost containment. I apologize because I did not get the accurate information about what the program was all about, and I did not give you written testimony, so I will make this very short because the kind of testimony I was going to provide is about access to the urban poor.

Our agency provides services in the urban dwellings, and we do have difficulty in providing access in terms of providers going into public housing, and also the safety of the caregivers. I will not bore you with the subject right now because I will present testimony so you can read it in detail, because I know this is not the appropriate forum. But I did want to make the point that when you do look at your health care plan and health coverage, please consider the home health care benefit, because this is certainly an alternative to hospitalization. It will shorten hospital stays and provide continuity of care in the home. So I did want to make this point, and that is why I didn't completely withdraw from the podium today.

Do you have any questions about home health services? (no response) I should say that the New Jersey State Nurses

Association will work very closely with you in carrying out any of these cost-effective plans.

ASSEMBLYMAN FELICE: I really appreciate your input. I have to say, knowing the State Nurses Association and what they are doing, it is the direction that is one way to really help health costs containment. There are many more programs that are home- and community-based, rather than hospital- and institution-based. I think that is the direction I think the whole country is looking at for reducing health care costs. Not only is it more financially beneficial to the communities in the State, but it is also a program that is more beneficial to the patients themselves to actually be--

MS. CONTESSA: It is a more humane program.

ASSEMBLYMAN FELICE: It is a proven fact that patients get better more quickly in their own environment, than they do in a hospital or an institution. I thank you.

MS. CONTESSA: Absolutely. You have done your homework. Thank you very much.

ASSEMBLYMAN FELICE: Well, it is our pleasure.

ASSEMBLYMAN McGREEVEY: Sylvia, just to take off on what Nick has said, and Nick has been sort of a leader in this field-- After looking at the whole question of accessibility in the Uncompensated Health Care Trust Fund, we will be moving into the hospital regulatory area, and the third area we will be looking at will be long-term health care.

MS. CONTESSA: Oh, it will be? Okay.

ASSEMBLYMAN McGREEVEY: Yeah, specifically.

MS. CONTESSA: I think our communication broke down here, okay.

ASSEMBLYMAN McGREEVEY: And one of the things that the State Nurses Association, which both Nick and I have worked closely with-- One of the things that has been very much in the forefront that they have been concerned about is community-based health care services and delivery. That is

something we will fully explore next spring, and something we will spend a considerable amount of time on.

MS. CONTESSA: Oh, next spring. Okay, I will be happy to help you. Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you. Is Joseph Scherber here? (no response) Our last witness, unless there is anyone else who would like to testify, will be Mr. Alan Kaufman, from the CWA. Thank you very much for your endurance, Mr. Kaufman.

A L A N K A U F M A N: Thank you for the opportunity to testify before this Commission. I am the Health Care Coordinator for the Communications Workers of America New Jersey. We represent in New Jersey approximately 60,000 workers; workers who work for the State of New Jersey, for counties and municipalities, plus people who work for the telephone -- for Bell and AT&T.

I have presented you with written testimony. I am not going to follow all of that. I will just try to summarize the basic position. It has been a long day.

Health care at the bargaining table is the number one issue, and it is the most problematic issue. As people may be aware, the Communications Workers of America recently concluded a very long and bitter strike against the NYNEX Corporation in New York. The issue there was takebacks in health care. This was from a very profitable company, which really had no economic justification in terms of problems they could show with their profits and books on the need to make savings that way. I anticipate, in the future, that it is going to be more and more problematic. I have been negotiating contracts for over 10 years, and I can sort of plot the amount of -- the number of times that health care has come up, and how that is increasing over time.

People would mention a number of years ago that it was a problem, that costs were going up. Now, if somebody tells me across the table that they are going up 20%, I sort of am

relieved because they could be telling me 40%. I have heard 40%.

There are negotiations now in Warren County where the demand on the table is that you will pay all future increases in health care premiums. That is something that will extend to the county. I think in Morris County, an association -- not CWA, but an association there -- agreed to pay $150 a year more toward premiums. That is a foot in the door. People who are negotiating around the State are telling me all the time that they are being put on notice that health care is going to be the number one issue next time they negotiate, and they are going to be coming after the benefits. Or, if they don't come after the benefits, there will be no pay increases.

So, health care is now the number one issue in terms of the unions being able to provide maintenance of living standards. I heard here today -- I know there were a lot of people from management who testified here today; I don't know if there was anybody else from a union except John Ronches -- about bare bones. We want a bare bones-- I don't even feed my dog bare bones. I am being serious. You know, my dog would look at me if I gave him a bare bone. It's got to have something on it.

But bare bones-- People are talking here about what should be in this minimum plan that people are talking about that everybody should have. If I were negotiating with that person across the table, I would say, "I'll take what you have." The people here are talking about bare bones. They are talking about giving less than they have to other people. This is the attitude that exists everywhere I go in the State. It is an attitude like when I grew up, the idea was that people wanted to pass on to the next generation something better than they had. I am hearing the exact opposite thing now.

We have two-tiered systems. I was forced into a situation myself, negotiating a contract, starting with people

who picked up recyclables in Burlington County who had no benefits. They were making, like, $5 an hour, no benefits. We got them health insurance coverage for the individual, not for the family. They had to wait nine months before they got that coverage, where the drivers, who are higher paid, could get it right away. That is sort of like a two-tiered system. I am hearing more of that two-tiered system, and it is going to happen in health care. We are going to end up-- Demands on the table now -- what we see now-- We are going to pass on to our kids less than what we have now. To me, that is like-- Going through the hearing today is like being in "never-never land." It is mind-boggling to be here, and sit here, and hear people talking about all the patchwork programs, and all the problems, and we give people bare bones--

I'm telling you now-- I am off that sheet now. This is just a very honest, direct statement I am making, something I would say across a table during negotiations, not that it necessarily has -- it is going to get me what I want, but just to say honestly what I feel: I mean, we are not talking about socialized medicine. I heard you talk about socialized medicine. Britain is not a socialist country. They have health care. Canada is not a socialist country. They have health care. This is the only country -- industrialized country -- where we put ourselves in the same category as South Africa; a country that doesn't have some sort of plan that guarantees us a right -- a right for people to have health care.

This is the only country! What are we talking about here? Because you are employed by McDonald's, because you are employed by the Occupational Training Center in Burlington County and you pick up recyclables, which is a very important thing to do, somehow you don't get health insurance? Or, as Mr. Fein said, somehow there was some break in his service and his wife, who has cancer, can't get health care? It is just like, what are we thinking about, with people talking about bare bones and all that?

To me, the whole conversation is off target. Now, back in the late '40s, labor lost the battle for national health care. You know, it's communism, it's socialism, it's something. Darn it, it is health care for everybody. We have education for everybody. Everybody pays taxes. Are these socialistic measures? These are things that people need. Everybody needs health care. That is not socialism. That is something that everybody needs. The very people who sat here from management have this health insurance. You know, they have it, and they are talking about, "Well, we don't know if we can afford it," or, "It shouldn't be done," or whatever it is, or it is something else.

So, labor lost the battle back in the '40s. They have had national health care on the agenda, and the whole bugaboo has been socialism and communism and all that, and we went to the negotiating table. It can no longer be done at the negotiating table. That is what I tell my people. It can no longer-- It cannot be done at the negotiating table, so there has to be a comprehensive-- That is my whole point: There has to be a comprehensive plan that everybody is entitled to -- every worker, every individual, employed, unemployed, senior, whatever. They have to have access to it. The mandated benefit level would be comprehensive care. I think philosophically we have to get ourselves to that point. We can then talk about specifics on how you are going to finance it.

In the State of New Jersey, we have sort of that type of system, right? The employee doesn't pay anything for it. Your worker in the State of New Jersey, and the State Health Benefits system, plus the teachers who are here -- 100-and-some-odd thousand of them in the State Health Benefits system, you know, who work for the localities -- the county people in the State Health Benefits system-- You are paid for; the spouses and children are all paid for. The bill comes in, and the bill is paid for.

Now, there is a problem with that. I think we need to talk about cost containment. There is a real problem with that. I don't agree with that. But the aspect of comprehensive-- People are covered, right? I think that type of a system should be extended to everybody in New Jersey -- all right? -- at a level of benefits where people get what they need.

You can get into the questions of, "Well are we going to put somebody on a respirator for 20 years?" or, "Are we going to pay for every kidney transplant?" We can get into those types of questions, but those are sort of like diversionary issues. I think people are entitled to basic care, whatever they need. I think that is where we should start from. We can't be negotiating all this across the table and have one system for the wealthy people who can afford whatever they want, and one system for the people who are employed. I can tell you that employed people have benefit levels that vary all over the place. It is very uneven. Whether or not their spouses are covered varies. Whether or not they have it when they retire varies. So it is all over the place, and we are just going to add a hodge-podge now of things to dam up the holes where people aren't covered.

Some of the things we are doing increase the costs. For instance, the State of New Jersey, in order to contain costs, created the PPO. Okay? Now, do you know what they are going to do? They are hoping-- They now reimburse the HMO by law what they pay for the traditional health insurance. Right? So they created this PPO. Now, they are going to say, if the PPO rate is less, they are going to reimburse the HMO at the level of the PPO, rather than the traditional plan. Now, that is going to impact on our workers. So, they are using these strategies to cut the benefits, rather than to go directly at some plan with a single payer which negotiates en masse with all the providers, to say, "This is what these

things are worth, and this is what you are going to get paid for them if you want to practice here."

It can be done fairly. In Canada, that is the way it works. I understand the average income in Canada of a physician is not much less than it is in the United States, and the physicians there participate. So this type of thing isn't so outlandish. It is not some communist or socialist bugaboo. It works in Canada, and unless you do that, we are going to have the same type of problems, because the things we are talking about-- Uncompensated care is not going to control-- Covering uncompensated people now-- A lot of employers-- Some of the big employers want that because they feel they are being taxed, in a sense, to pay for the employers who aren't.

That is a management concern. I am concerned about that to a certain extent, because when they come back they say what they want us to pay for that. So that is a problem. I don't think it is really fair that that takes place, but that is a very limited perspective on the whole thing.

Uncompensated care is just one part of it. We have overall costs that have to be contained, and you can do that with a single-payer system. So basically what I am saying is, there should be one set of standards for everybody. It should be a right for everybody under the system. Take all the existing moneys that the employers put in, that everybody else puts in, and put that in a single pool, and you will have to adjust taxes and other things in some way that is fair to make up whatever you need extra to cover the rest.

That is basically our position. That is the only way, in terms of labor, that we are going to maintain our benefits and not be in constant strife over the issues of health care takebacks which we see coming down the line.

ASSEMBLYMAN McGREEVEY: Thank you very much for your testimony. Mr. Felice?

ASSEMBLYMAN FELICE: You say all this, and then you say, "Well, you need some kind of a basic health care plan." Isn't that what we are also saying? Some say, "Bare bones." But what you're saying is that everybody is entitled to health care. Well, in New Jersey, whether they can afford it or not, they do have uncompensated care, which is a step in the right direction to ensure that.

But you are also saying that if a person doesn't want to work, who is able to work, the rest of us should make sure that he has health care; that he or she should have health care. I think what you are really saying is that, regardless of what you do or say or want to do, there should be coverage for not only health care-- Then, of course, why not make it for everything else you need, and make sure that we have food for these people, and make sure they have the same conveniences as those people who are working. Aren't you saying that?

MR. KAUFMAN: In all due respect, sir, I heard your comments before. I mean, you have baited people who were here, in all due respect. We're talking about people who are working. There are people who are working who do not have health coverage. What you are saying to me is-- You are making an argument that if you sit in front of a welfare board, you'll see somebody drive up in a Cadillac. I have seen it. I worked at a welfare board. But most people do not drive up in a Cadillac. The overwhelming majority do not drive up in a Cadillac. So, by your saying that somehow there are people out there-- The problem is that there are people out there who don't want to work, and they are not covered.

ASSEMBLYMAN FELICE: I am asking you that question. You are saying that regardless of what you do, you want that coverage.

MR. KAUFMAN: The problem is not that there are people out there who don't want to work. The vast majority of the people who are not covered are working. I can tell you people

that I know about who are working who have minimal or very little coverage. So it is not-- Don't focus the argument on the people who don't want to work. There are people who are working who are not adequately covered. If there are a few people out there who get the benefits of a system that covers everybody, so be it, because the vast majority of people I deal with are working people, honest people who are not trying to get over on anybody. That is the issue, so let's not focus on some of those people who try to get away with something.

ASSEMBLYMAN FELICE: You're focusing on that. I am asking a question of you, and I want an answer.

MR. KAUFMAN: Everybody should be covered.

ASSEMBLYMAN FELICE: All right. Everybody should be covered, regardless, and there should be one basic health plan.

MR. KAUFMAN: Yes.

ASSEMBLYMAN FELICE: Okay. That is the question I asked you.

Number two, do you think the system in Canada and Massachusetts is 100%? Is that system working all right?

MR. KAUFMAN: There is nothing that is 100%. I am talking about Canada because I see it as a model, the system that most closely parallels the United States. It operates, basically, on a very similar system to what they do here. Their income has not been negatively impacted, so they are all not going to leave and not go to medical school. People have freedom of choice of going to the doctors. That has always been the one thing about-- People felt they would not have freedom of choice going to the doctors, but we are already with these managed care programs, and all these PPOs-- We are already circumscribing the way people go to the doctors far more than some of these other countries where they have universal health care.

ASSEMBLYMAN FELICE: My only concern was, those people who really need that help and that care, whether they be the

aged, the disabled, and all, that these programs don't hurt the very people they are supposed to help. That is my concern, quite honestly.

MR. KAUFMAN: I don't see how anything I am saying would hurt--

ASSEMBLYMAN FELICE: No, no, I am just talking about programs such as Massachusetts has. I think we are finding that doctors are no longer accepting these patients because they feel they would rather not practice anymore in that state, or not take any Medicare or Medicaid patients. Those are the very people who need the help -- the aged, the handicapped. If we lose the capability those people want to serve them, then we are really in trouble. Then we have an area where the practice and the medical needs for these people are not being offered to them. That is a concern of mine.

MR. KAUFMAN: As I understand it, from people who have been to Canada, the doctors are not leaving Canada to come here to practice. They are happy with the system and they are getting adequately compensated, and everybody is taken care of. We wouldn't advocate doing something that would prevent people from getting care because a doctor felt he wasn't being compensated. The fact of the matter is, people are not being given care now. I think there is a tremendous cost to society that is a hidden cost. I mean, how much does it cost society when a pregnant mother can't get a decent meal or decent prenatal care and you have a brain-damaged or some damaged child who then costs you $100,000 a year? Or when people I know who have inadequate coverage don't go to the doctor, and when they finally get there the costs of taking care of that person are astronomical? If you give people coverage and you give people preventative medicine, I think that some of the costs are actually reduced. So, it is not just that if you cover everybody the whole system is by some proration going to be that much more expensive. You are going to make real

savings, too, in terms of providing an adequate level of care to people.

ASSEMBLYMAN FELICE: Mr. Kaufman, I appreciate your input. I think one of the things you mentioned is one of the factors that are up for discussion here. We can't get people to go into the field of obstetrics, to be obstetricians, because of the malpractice and all -- where there is a tremendous need for prenatal care, for doctors in that particular field. That is one of the places where there is a need, and yet we are driving people out of that profession because of the high cost of malpractice in that one field.

There is a tremendous need in our country for that. That is the kind of thing we hope will never happen, you know, that we get to that point where we are getting in the professions people staying out of that profession because of the tremendous pressure of the malpractice and the costs of the fees that are being given to them in that field, where they couldn't make enough money to pay the malpractice fees, so they are not going into that particular field. I hope it doesn't happen to the other fields, because that would be a real disaster, not only to our State, but to the country.

ASSEMBLYMAN McGREEVEY: Thank you, Mr. Kaufman.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: If you could just indulge me for two minutes, I just have a statement. Charles Marciante was going to be here, but unfortunately he couldn't be here. He submitted a statement, and I would like to just read it into the record. Hopefully my reading skills are up to par. This is testimony submitted by Charles Marciante for July 18, 1990:

"The N.J. State AFL-CIO welcomes this opportunity to present testimony to the Assembly Health Care Policy Study Commission. Organized labor has called health care costs, availability, and quality the most critical social and economic issue confronting out State in the 1990s, and our recent

involvement with the Governor's Special Health Care Cost Commission has only served to confirm this contention.

"Assuredly, there are no simple answers to the health care crisis confronting our State and nation. Costs are being driven by our aging population, workers whose employers are not providing health coverage, the ongoing development and increasing use of high technology diagnostic and therapeutic machinery and tools, the high cost of the dreaded disease of AIDs, Medicare and uncompensated care costs shifting, and normal wage/price inflationary pressures. The complexities inherent in our existing health care system are enormous and real reform must be multifaceted, encompassing regulatory and certificate of need procedures, our DRG and reimbursement system, insurance availability and affordability, and uncompensated care funding.

"Organized labor has felt the pinch of rising health care costs and the inequitable distribution of uncompensated care costs as much as any other segment of society and more than most. It's estimated that employer health care costs rose an average of 20.4% in 1989 and some 45% of after-tax corporate profits are now being siphoned off by the cost of health care. Not only does this place U.S. employers at a severe competitive disadvantage in our global economy, but it transfers an ever-greater share of health care costs to employees.

"Workers have seen their share of insurance expenses nearly triple over the past five years due to increased deductibles and co-pays. A 1989 survey by one of our international unions showed that insurance premium contributions by their workers jumped by 70% from 1987 to 1989, while wages increased by less than 10%. This drain on benefits has had a demonstrable impact on employer/employee relations. Major strikes which featured health care insurance benefits as the paramount issue skyrocketed from 18% in 1986 to nearly 80% in 1989.

"In New Jersey, all of this has translated into an increasingly serious situation for many union health benefit funds which have seen their surplus revenues severely depleted in recent years. Some funds are now even approaching bankruptcy status because of rising costs.

"These problems are being exacerbated by growing evidence that unions and union employers are being 'victimized' by our present system of funding uncompensated care and are, in effect, subsidizing nonunion competitors who do not provide health care benefits. Not only does this dump greater numbers onto uncompensated roles -- to be covered by those who do provide insurance -- but it enables nonunion employers to unfairly underbid their union competitors who pay their employees' health insurance coverage.

"A 1989 Eagleton survey shows that some 37% of New Jersey's 158,000 small business firms offer no health insurance" -- and he has that underlined -- "for their employees. Even worse, a significant proportion of these firms indicated they would have no interest in providing coverage under any condition. So desperate has the situation become for a number of our construction trade funds that they are threatening to drop health care benefits for their members altogether, opting instead for increased wages and other benefits. If this happens, it would bankrupt the Uncompensated Care Trust Fund in short order, creating a crisis of unparalleled proportions. No one is questioning the merit of providing free health care to the truly indigent, but clearly something must be done to eliminate exisiting inequities and spread the cost of uncompensated care more evenly across the social spectrum.

"Among other issues, the Governor's Commission on Health Care Costs has been studying the question of health insurance coverage and availability in some detail. While it's still too soon to say what the Commission's final

recommendations will be, a number of promising proposals are under review. They include" -- he doesn't have 1), but I will label them:

1) "Providing options to individuals and small groups to purchase 'bare bones' coverage which offers a basic level of benefits and, in some cases exempts individuals and small groups from having to purchase mandated benefits."

Next he has: "Pricing health insurance for individuals in New Jersey on a sliding scale to reflect income."

Next: "Including managed care and utilization review controls in individual and small group coverages and stress disease prevention in policies. Insurance now pays for illness, not wellness. For instance, policies do not cover a $15 flu shot, but will pay for treatment of influenza and its complications."

Next: "Spreading the adverse or 'poor risk' selection process across the entire insurance industry to relieve some of the excess burden now carried solely by Blue Cross/Blue Shield and its nearly four million subscribers."

Next: "Developing an affordable, long-term care policy for the elderly."

Next: "Revising Federal tax laws which now allow incorporated firms to claim a 100% deduction on health insurance premiums but limit partnerships and sole proprietorships to only a 25% deduction. Small business deductions should be increased to 100%."

Next: "Mandating community rated coverage for all health insurers, not just Blue Cross/Blue Shield."

Next: "Upgrading Blue Cross/Blue Shield forecasting and auditing procedures which have been criticized in at least two studies."

Next: "Prohibiting insurers from arbitrarily dropping someone from coverage due to illness, or increasing their premiums so radically that they are forced to drop coverage."

Then he goes on in the next paragraph: "In New Jersey, any program to make health insurance more available and affordable must necessarily deal with our system of funding uncompensated care which is expected to total as much as $700 million in 1990, most of which is shouldered by individual and third-party payers. It represents more than 10% of hospital revenues and accounts for about 19% of the average Blue Cross/Blue Shield bill. Along with the enormous Medicare cost-shifting we have experienced since 1988, it appears to be primarily responsible for the unaffordability of basic health care insurance in our State."

New paragraph: "We have already detailed the gross inequities in funding the uncompensated care and Medicare cost shifts. These costs have fallen most heavily on New Jersey employers and trade unions that do provide health insurance coverage. Conversely, businesses that provide little or no coverage to their employees are exempt from the uncompensated care burden and there are no existing incentives for them even to provide coverage."

New paragraph: "A few statistics bear this out. Of New Jersey's one million uninsured, it is estimated that some 43% are employed (either full-time or part-time) and another 35% are dependents of employed persons. Only 20% have family incomes <u>below</u>" -- "below" is underlined -- "the poverty level, while 35% have incomes of at least <u>three times</u>" -- emphasized -- "the poverty level ($12,600 for a family of four). Of the State's total uncompensated care bill, more than 60% is bad debt; the rest is charity care. Clearly, much can, and should be done to spread the costs more fairly throughout the population.

"Again, the Governor's Commission has heard many promising proposals for reducing the uncompensated care burden and spreading the costs more evenly."

Then in a series:

"Expand Medicaid eligibility in New Jersey (to incomes as much as 185% of poverty), thereby increasing the amount of Federal matching funds. In line with this, we must create incentives for counties to enroll more eligible Medicaid recipients and for more eligible individuals to actually apply for the benefits."

Next: "Consider a program wherein non-poverty but low-income individuals are allowed to 'buy-in' to Medicaid coverage."

Next: "Increase the Medicaid reimbursement rate to physicians and/or require them to treat a certain percentage of Medicaid recipients. New Jersey's reimbursement rate is currently among the lowest in the nation. As a result, more than 50% of our physicians will not handle Medicaid patients, forcing them instead to seek care in high cost emergency room settings."

Next: "Revise our existing system for collecting unpaid or bad debt hospital bills, or perhaps even exclude it from uncompensated care coverage. Hospitals currently have little incentive for curbing bad debt, since they are reimbursed for it regardless. As a result, some 62% of all uncompensated care costs is in the form of bad debt."

Next: "Consider a separate funding source for AIDS treatment and redefine the treatment and services uncompensated care will pay for."

Next: "Consider a general tax or other broad-based funding source to insure that all State residents and groups contribute in some way to uncompensated care funding. It has been determined to be a societal priority and should be at least partially funded in that way."

Next: "Finally, and most importantly, either require all New Jersey employers, and out-of-state employers bidding on State work to provide comprehensive health insurance for their employees, or initiate a tax on employers <u>who do not</u>" -- "who

do not" is emphasized -- "provide coverage at a rate equal to the cost of an average Blue Cross/Blue Shield individual or family premium, as has been proposed in a number of other states. Certain incentives, or creation of a 'bare bones' insurance package will have to be developed for some small businesses which otherwise would not be able to afford to provide coverage."

Last paragraph: "Yes, the State AFL-CIO does believe that it is feasible, and indeed necessary, to establish a State-mandated level of employee health care coverage in New Jersey. And, we are encouraged by the near unanimity on this point that has been expressed by those testifying before the Governor's Commission. Given the present state of our health care crisis, we must initiate a system wherein everyone pays their fair share, or we will quickly be confronted by a massive consumer and payer revolt. Thank you. Charles Marciante."

That is the President of the AFL's testimony before us. If anyone wants a copy, we can provide that for you.

Just to conclude, I want to say thank you, especially to Nick Felice, who has served with vigor, and also to Jackie Mattison, the staff members, and to Robbie Miller, who are all here today.

We tried to focus in on, you will notice with our first question, obviously the reality of the problem. Secondly, we focused in on the hospitals and the problems they are facing in terms of the impact of the uncompensated -- their management -- and also in terms of the financial reimbursement of hospitals for health care delivery.

Today we tried to focus in on that question. Frankly, we would have liked more of an exchange with the business community, but we were focusing on the question of recognizing that there is, by Department of Health estimates, an 18.35% markup on hospital bills by those who provide health care coverage. What is the solution to bringing more businesses to

the health care coverage table? I think we have seen some testimony -- and there is no need to rehash all of it today -- which ended significantly differently.

The next aspect we will be focusing in on will be the question of Medicaid eligibility, and we will probably be focusing-- We will probably be holding the next hearing during the month of August in Newark. Nick has been very helpful in addressing that concern.

So I just wanted to thank everyone who was here today for your time and for your attention. We will be putting out the next meeting notice in early August. Thank you very much.

(HEARING CONCLUDED)

APPENDIX

THE CITIZENS' COMMITTEE ON BIOMEDICAL ETHICS, INC.

Oakes Outreach Center
120 Morris Avenue
Summit, New Jersey 07901-3948
(201) 277-3858

Organized	July 1983 (Drew University, Madison, NJ)
Incorporated:	New Jersey, 1984, Nonprofit
Membership:	Board of Trustees - 44 Contributing Members - 575 Non-contributing Members - 2,000
Board of Trustees:	See Attached
Contact:	Mary S. Strong, Chairman (201)277-3858
Qualifying Status:	The Citizens' Committee on Biomedical Ethics, Inc. is a publicly supported organization as described in section 509(a) of the Internal Revenue Code, exempt from taxation under section 501(c)(3)
Geographic Area Served:	New Jersey
Programs/Services Offered:	Public forums throughout New Jersey sponsored by the Citizens' Committee and/or co-sponsored by another organization(s) as well.
Population Served:	New Jersey citizens

Corporate & Foundation Sponsorships

CIBA-GEIGY Corporation
Morris Avenue
Summit, New Jersey 07901
Elizabeth A. Moench, Executive Director

The Fund for New Jersey
57 Washington Street
East Orange, New Jersey
Mark M. Murphy, Executive Director

Hoffman-La Roche, Inc.
Nutley, New Jersey 07110
Rosemary H. Bruner, Director,
Department of Community Affairs

The Greenwall Foundation
370 Lexington Avenue
New York, New York 10017
John L. Dugan, President

The Home Life Charitable Trust
253 Broadway
New York, New York 10007
John P. Meyerholz, Senior Vice President

New Jersey Committee for the Humanities
35 College Avenue
New Brunswick, New Jersey 08903
Miriam Murphy, Executive Director

The Prudential Insurance Company of America
Prudential Plaza
Newark, New Jersey 07101
Richard W. Matthews, Program Director

The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, New Jersey 08540
Carolyn H. Asbury, Program Officer

The Schultz Foundation
697 Route 46
Clifton, New Jersey 07015
William S. Rigg, Executive Director

The Warner-Lambert Foundation
201 Tabor Road
Morris Plains, New Jersey 07950
Ewart V. Thomas, Secretary,
Contributions Committee

The J.M. Foundation
60 East 42nd Street
Suite 1651
New York, New York 10165
Jack Brauntuch, Executive Director

The Merck Company Foundation
P.O. Box 2000
Rahway, New Jersey 07065-0900
Catherine J. Freeman, Associate Council

The Charles E. and Joy C. Pettinos Foundation
437 Southern Boulevard
Chatham Township, New Jersey 07928
Robert W. Parsons, Jr., Chairman

Hyde and Watson Foundation
437 Southern Boulevard
Chatham Township, New Jersey 07928
Robert W. Parsons, Jr., President

THE CITIZENS' COMMITTEE ON BIOMEDICAL ETHICS, INC.

Oakes Outreach Center
120 Morris Avenue
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Nancy H. Brach, M.A.
Executive Director, National Council on Alcoholism of North Jersey, Inc.

Ronald L. Caplan, Ph.D.
Assistant Professor, The State University of New Jersey Rutgers, Department of Urban Studies and Community Affairs

Rev. Walter Debold
Professor, Seton Hall University

Rita Dyer, R.N.
Nurse Discharge Planner, Overlook Hospital

Richard B. Ellis
Independent Consultant
Retired, AT&T

Catherine J. Freeman
Associate Counsel, Merck Co., Inc.

Helen Hoch, Ed.D.
Associate Professor, Jersey City State College, Department of Biology

Donald G. Jones, Ph.D.
Professor, Drew University, Department of Religion

Jane Isaacs Lowe, M.S.
Assistant Professor, University of Pennsylvania

Richard W. Matthews
Program Officer, The Prudential Foundation

Ernest M. May, Ph.D.
Board of Trustees, Jersey City Medical Center

J. Joel May
Senior Consultant, The Pennington Group

John F. Merrigan, M.P.A., L.N.H.A.
Administrator, Morris View Nursing Home

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Director, Quality Assurance Office, Muhlenberg Hospital

Elizabeth A. Moench
Executive Director, Public Affairs, CIBA-GEIGY Corporation

Geraldine P. Moon
Vice President, Professional Practice and Quality Assurance, New Jersey Hospital Association

Nancy J. Moore, Esq.
Associate Professor, The State University of New Jersey Rutgers, The Law School

Michael A. Nevins, M.D.
Geriatrician
Former President, American College of Physicians

Martin L. Parker
Independent Consultant

Catherine H. Pignatello, R.N.
Administrator of Professional Services
Essex Community Health Service

David M. Price, Ph.D.
Professor, UMDNJ, Newark

Ellen Lewis Rice, Esq.

Robert J. Schermer
President, Healthplans, Inc.

Robert L. Strong, Esq.

Marietta Taylor
Health Analyst

Rev. Charles A. Weinrich
Director, Department of Pastoral Care, Overlook Hospital

John H. Wood
Principle, Burkewood Communications Corp.

(4.3.90)

THE CITIZENS' COMMITTEE
ON
BIOMEDICAL ETHICS, INC.

Oakes Outreach Center
120 Morris Avenue
Summit, New Jersey 07901-3948
(201) 277-3858

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THE CITIZENS' COMMITTEE ON BIOMEDICAL ETHICS

MISSION STATEMENT

The primary purpose of the Citizens' Committee on Biomedical Ethics is to create an environment for grassroots citizen exploration of the ethical issues in health care presently facing individuals, institutions and policy makers, and to provide mechanisms by which these issues can be broadly communicated to the society at large.

OUR CURRENT FOCUS

Presently the Committee is:

* Offering ethics workshops combined with debating programs in inner city and suburban high schools, plus developing a workbook for the course;

* Informing professionals and the public regarding comprehensive (universal) health insurance;

* Nurturing the development of the New Jersey Assembly for Health Decisions and its Legislative Observer Corps;

* Assisting New York in its formation of "The Citizens' Committee on Health Care Decisions of New York State";

* Continuing to develop the Evolving Health Care system (computerized, simulated health planning);

* Conducting Living Will and Surrogate Decision Making Seminars for employees of local corporations;

* Facilitating Legislative Seminars in local acute care hospitals;

* Focusing on ethical dilemmas as part of The Committee's on-going community education;

* Increasing the clergy's awareness of and assisting them in counseling for end-of-life decisions in health care;

* Creating, developing and training long term care ethics committees;

* Forming a Southern Chapter of the Committee in the Camden County area.

In addition the Committee now has over 575 paying memberships with approximately 2000 other individuals who are interested in the community and its work. Also the committee has reached well over 24,000 citizens through its educational outreach in New Jersey.

The Committee is constantly keeping abreast of available health care services and technology in our ever changing social environment. Thus, we are able to think ahead about the ethical implications and keep the public informed about its choices.

BACKGROUND

In 1983, five citizens of New Jersey came together to discuss the implications of reports then recently issued by the United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Of the many observations made by the President's Commission, one of the most telling was that much of what medically used to be in the hands of fate is now in our hands. This development has far-reaching legal and ethical implications which clearly have found medical professionals and lay people alike unprepared to make the choices that are now presented to them.

Wishing to bring the findings of the President's Commission to the attention of New Jersey's citizens, and particularly to begin to provide for a more informed citizenry, this informal group of five conducted a public forum on October 18, 1983 at Drew University, Madison, New Jersey, for this purpose. Alexander M. Capron, who had served as the Executive Director of the President's Commission, was the featured speaker. In the course of the forum, an interdisciplinary panel made up of ethicists, lawyers, psychologists, administrators, social workers, nurses and physicians responded to questions from the audience of 250 citizens.

So successful was the forum, that it was decided to establish, on November 15, 1983, the Citizens' Committee on Biomedical Ethics. Formal incorporation in New Jersey followed in August 1984. In the course of the first year, the Committee was run by a steering committee with assistance from an advisory group.

Between 1983 and May 1985 forums were held throughout the State in order to test the interest of the public in addressing these perplexing and concerning issues. The response indicated beyond a doubt that the citizenry desired and felt the need to become better informed. In 1986, with substantial funding from the Robert Wood Johnson Foundation, the Prudential, Warner Lambert, the Schultz Foundation and others, the Committee held over 300 community meetings reaching approximately 20,000 individuals At the same time, the Citizens' Committee conducted two public opinion surveys on a wide range of medical-ethical issues, including living wills, the termination of treatment and the allocation of

limited medical resources. The data, issued in August 1988 in a final report entitled, *Your Health, Your Choice, Whose Decision* (Attachment A) has been widely disseminated to the public, media and the three branches of state government, as well as to key policy makers.

In 1989, the Citizens' Committee launched another major project, the development of the Assembly for Health Decisions. Designed to provide a stable forum within which the public can examine emerging issues in ethics in health care, the Assembly is to give form to the public's opinions so that they can actually play their role in shaping public policy.

The approach of the Citizens' Committee is based on the conviction that citizens are responsible for their society. They are responsible for addressing the problems of health care systems which form an integral part of a humane society. It is, moreover, the conviction of the Citizens' Committee that these problems are too important to be left to hospitals, physicians, government authorities or the courts alone. The Committee believes that biomedical-ethical issues will receive their most advantageous attention when professionals and lay people address them together.

BASIC ASSUMPTIONS

* Cultural, legal and technological changes have created an environment where decisions on life and death must be made. This creates an acute need for the ordinary citizen to be involved actively in the public discussion on medical-ethical issues.

* Information and education are prerequisites for an intelligent public discussion of such issues if it is to be sensitive to the needs of a pluralistic society.

* Public discussion, to be more effective, should initially take place at the community level so that subsequent policy reflects the interests and values of the general public.

* The increased awareness of medical-ethical issues which result from such public discussion will help individuals and families to make prudent plans and wise decisions regarding the provision of medical care.

* Public discussion of this kind minimizes the need for legislation -- either as constraints on patients and their families or as additional regulation of the health care profession -- as it seeks reasonable public policies on health care.

GOALS

To clarify the ethical and social issues in health care;

To identify concerns of primary importance so that grassroots citizens can more effectively participate in forming public policy;

To provide a framework in which the general public can consider and resolve ethical conflicts encountered in the provision of health care;

To produce and disseminate information that accurately reflects the general public's attitude toward, and expectations of, modern health care;

To assist in forming guidelines and a national consensus on issues that appear to be most critical to the welfare of society.

ACCOMPLISHMENTS

1984 - 1985: 14 citizen forums were held including:
- Bergen Community College Conference
- Jersey City State College Conference
- Princeton Theological Seminary Conference
- Woodrow Wilson School, Princeton, Conference

1986 - 1989: *Your Health, Your Choices, Whose Decision*
To give shape and purpose to a grassroots movement in New Jersey, the Citizens' Committee conducted a two-year (1985-87) project - ***Your Health, Your Choices, Whose Decision.*** A statewide program of public discussion of the ethical issues in medical treatment, including the allocation of medical resources, the program reached more than 20,000 citizens by the end of 1987. These programs numbered approximately 300 and were possible because of the time and expertise donated by many professionals - nurses, lawyers, doctors, university faculty, clergy, journalists. Evaluated as an in-kind donation, these services amounted to approximately $70,000.

An integral part of this project was an accompanying statewide survey of public opinion on a wide range of medical-ethical issues. The questionnaire was developed and donated as a gift by RL Associates, a public opinion research firm in Princeton, New Jersey. The data generated from the survey was presented in a preliminary report May 7, 1987. The final report was presented early in August 1988 to the general public, the Governor, the Legislature and the Judiciary.

We are please to note that the Chairman of the Citizens' Committee is appointed to key decision-making bodies within the State that not only have input into health care expansion but also policy and regulation. These government bodies are include:

* Commission on Biomedical Ethics: Chairperson, Education Committee

* State Health Care Council (SHCC): Board Member

* Policy Planning and Development (PPD); Subcommittee of the SHCC

* Regional Health Planning Council (RHPC): Board of Trustees

* Advisory Council on Organ Transplantation: Chairperson Professional & Public Education

* The Chairperson of the Citizens' Committee also sits on numerous Boards of Trustees throughout New Jersey, in both the community and the private nonprofit sectors.

The Citizens' Committee members are frequently called upon by statewide and local organizations and associations in need of the citizen's voice. Such participation assists in the critical assessment of the ethical implications of social/health care issues.

ORGANIZATIONAL STRUCTURE

By-laws Committee: develop By-laws for The Citizens' Committee; ensure procedures specified in By-laws are executed.

Nominating Committee: ensure that The Committee maintains a full membership; evaluate services of the subcommittees in carrying out their assigned activities.

Strategic Planning Committee: appraise the Citizens' Committee of activities and recommend an appropriate plan (short and long range) for future accomplishment of the Citizens' Committee's overall goal.

Personnel Committee: develop job descriptions for staff; determine salary; recruit, interview and select personnel and evaluate staff performance.

Finance Committee: prepare the annual budget; establish and maintain financial records.

Public Relations Committee: make broad use of local and regional newspapers to publicize meetings and local citizen participation; inform and work with key groups as resource for sponsorship of various conferences and seminars; recruit volunteers from local communities as group discussion leaders in their community.

The Citizens' Committee has adapted an interdisciplinary approach to deal with complex issues. The Board of Trustees and the membership represent a wide range of professional backgrounds - doctors, nurses, social workers, teachers, lawyers, clergy and ethicists as well as large numbers of lay people. As stated earlier:

> "The approach of the Citizens' Committee is based on the conviction that citizens are responsible for their society. They are responsible for addressing the problems of health care systems which form an integral part of a humane society. It is, moreover, the conviction of the Citizens' Committee that these problems are too important to be left to hospitals, physicians, government authorities or the courts alone. The Committee believes that biomedical-ethical issues will receive their most advantageous attention when professionals and lay people address them together."

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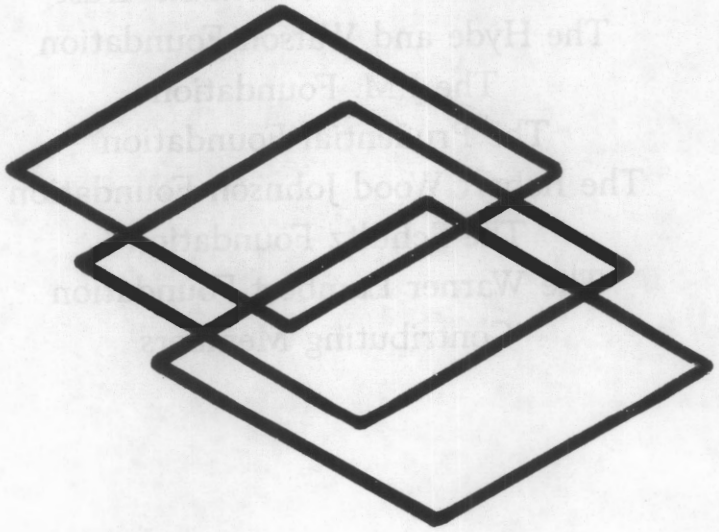
Your Health,
Your Choices,
Whose Decision

Final Report



The Citizens' Committee on Biomedical Ethics, Inc.

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FUNDERS

The Edna and Jack Belasco Foundation
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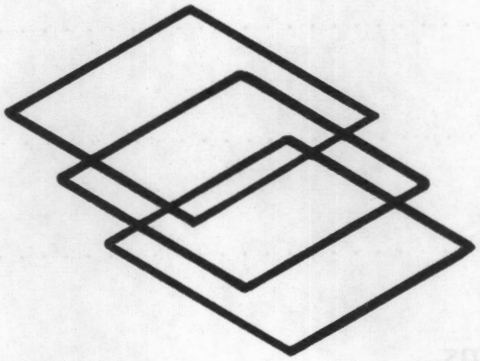
The Fund for New Jersey
The Greenwall Foundation
Hoffmann-LaRoche, Inc.
The Home Life Charitable Trust
The Hyde and Watson Foundation
The J.M. Foundation
The Prudential Foundation
The Robert Wood Johnson Foundation
The Schultz Foundation
The Warner Lambert Foundation
Contributing Members

Your Health,

Your Choices,

Whose Decision

Final Report



Presented by

The Citizens' Committee on Biomedical Ethics, Inc.
24 Beechwood Road
Summit, New Jersey 07901-2511
(201) 277-3858

22X

Table of Contents

23X

PREFACE

The Citizens' Committee on Biomedical Ethics is pleased to present the final report on its statewide project - *Your Health, Your Choices, Whose Decision.* A two-year program (1985-87), it was designed to provide the means, at a grass-roots level, for a continuing discussion by the citizens of New Jersey, of the ethical issues, present and emerging, in contemporary health care.

In order to accomplish this, the Citizens' Committee provided a forum throughout the state in which citizens of every background were able to become informed, ask questions, share concerns, and begin to probe highly complex issues. At the same time, the Committee conducted a survey of public opinion on these same issues, the findings of which constitute a major part of this report.

The opinions and preferences of New Jersey citizens, which this report documents, are remarkable for their innate sense of what is appropriate, for the moderation and the respect for life and humane values they so clearly reflect. It is my expectation that this report will bring encouragement to health care professionals and medical institutions providing care to patients, and to health care policy makers and regulators as they contemplate legislation and regulations that are at once humane and respectful of our social and ethical pluralism, as well as that moderation so visible in the public opinion outlined in this report.

The Roman tribune, Tiberius Gracchus (163-133 B.C.), used to say of the citizens of Rome, "I must follow them for I am their leader." The need to know the thinking of citizens has never been more important than it is today when our society wrestles with issues that reach to the core of personal and social values. And since ours is a representative democracy, it is critical that elected officials be prepared, like Tiberius Gracchus, to follow those they represent as their leader.

Your Health, Your Choices, Whose Decision could not have been completed successfully without the efforts of our staff — T. Patrick Hill, Helen Blank, Brenda Rhodes — and the seemingly unlimited volunteer services so generously extended by members of the Board of Trustees, the Advisory Committee, and Participating Associates. Without the assistance of Dr. Michael Rappeport, President, RL Associates, Princeton, the public opinion research firm which supervised our surveys, the value of this report would be considerably diminished.

Though this report marks the completion of its first major program, the Citizens' Committee will continue to provide a statewide forum for public discussion of ethics and medical care as an indispensable means to reach reliable public judgments. These judgments will be setting precedents for the generations that follow, which gives even greater moment to our responsibility.

Mary S. Strong
Chairman

24X

Chapter One

ORIGINS

In 1983, five citizens of New Jersey came together to discuss the implications of reports then recently issued by the United States President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Of the many observations made by the President's Commission, one of the most telling was that much of what medically used to be in the hands of fate is now in our hands. This development has far reaching legal and ethical implications which clearly have found both professionals in the medical field and lay people unprepared to make the choices that are now available to them.

Wishing to bring the findings of the President's Commission to the attention of New Jersey's citizens, and particularly to begin to provide for a more informed citizenry, this informal group of five conducted a public forum on October 18, 1983 at Drew University, Madison, New Jersey, for this purpose. Alexander M. Capron, who had served as the executive director of the President's Commission, was the featured speaker. In the course of the forum, a panel made up of ethicists, lawyers, and physicians responded to questions from an audience of 250 citizens.

So successful was the forum, that it was decided to establish, on November 15, 1983, the Citizens' Committee on Biomedical Ethics. Formal incorporation in New Jersey followed in August 1984. In the course of the first year, the Committee was run by a steering committee with assistance from an advisory group.

On April 27, 1984, the Committee, with the support of Drew University and a grant from the New Jersey Committee for the Humanities, sponsored a second forum. Subsequently, three additional forums were held at Bergen Community College, Jersey City State College, and Princeton Theological Seminary. The following year, on February 12, the Committee sponsored a public forum at the Woodrow Wilson School in Princeton to discuss with New Jersey citizens and government officials the suitability of a state commission on legal and ethical problems in the delivery of health care. This step was taken by the Committee in response to the decision of the New Jersey Supreme Court in re Claire C. Conroy (1983).

OPERATING ASSUMPTIONS

In addition, that decision helped to shape basic assumptions which now motivate the work of the Citizens' Committee:

- Cultural, legal, and technological changes have created an acute need for the ordinary citizen to be involved actively in the public discussion of medical-ethical issues.

- Information and education are prerequisites for an intelligent public discussion of such issues if it is to be sensitive to the needs of a pluralistic society.

- Public discussion, to be more effective, should initially take place at the community level so that subsequent public policy reflects the interests and values of the general public.

- Public discussion, to be fully effective, should eventually take place between the ordinary citizen and the health care professional, lawyer, ethicist, and public policy maker.

- The increased awareness of, and education in, medical-ethical issues which result from such public discussion would help individuals and families to make prudent plans for, and wise decisions in, the provision of medical care.

- Public discussion of this kind avoids the need for legislation - either as constraints on patients and their families or as additional regulation of the health care profession - as it seeks reasonable public policies on health care.

PROGRAM GOALS

Assisted by these assumptions, The Citizens' Committee has established the following goals as central to its mission. The Committee expects to clarify the ethical and social issues in the provision of health care. With this, and a better understanding of guidelines currently used in the provision of health care, the Committee expects to see the general public play its legitimate part in formulating policies that are in the best interests of all concerned.

The Committee expects to identify concerns of primary importance — whether ethical, social, religious, or technological — in order to show conflicting or complementary interests and obligations where they actually exist or might exist. The Committee sees this goal as necessary if the ordinary citizen is to deal successfully with the complexity of modern health care and avoid being overwhelmed by medical technology.

The Committee expects to provide a framework within which the general public can consider and resolve ethical conficts encountered in the provision of health care. By highlighting the dilemmas accompanying technological advances, such as the gastrostomy tube, or underscoring the conflicts of value between a patient's needs and the application of limited medical resources, the Committee expects to see established reasonable procedures for making decisions about what health care is provided, when it is provided, how long it is provided, and to whom it is provided.

The Committee expects that its work will produce a body of information accurately reflecting the general public's attitude towards, and expectations of, modern health care. Since New Jersey is a microcosm of the United States, ethnically, socially, and

economically, the Committee expects that its work will be of value to the endeavors of similar committees in other states and provide the basis for a reasonable national consensus on issues clearly critical to the well-being of society at-large.

YOUR HEALTH, YOUR CHOICES, WHOSE DECISION

In order to achieve its goals, The Citizens' Committee, on April 23, 1986, launched a two-year project - ***Your Health, Your Choices, Whose Decision.*** Between 1986 and 1988, volunteers with professional experience in medicine, nursing, home health care, ethics, law, and economics conducted local meetings in some 300 communities throughout New Jersey to solicit the opinions of the general public on a wide range of medical-ethical issues relating to the provision of health care: life-prolonging care to comatose terminally ill patients, the treatment of severely handicapped infants, surrogate motherhood, mandatory testing for AIDS, fetal tissue transplants, organ retrieval and transplants, genetic engineering, living wills, allocation of medical resources, and the right to basic levels of medical care.

TECHNOLOGY OVER ETHICS, ETHICS OVER TECHNOLOGY?

These are probably more difficult ethical problems than they are difficult medical problems. Today, medical care has at its disposal an array of protocols which can be used. The painful question is, should they be used? The overriding goal of the Citizens' Committee, through ***Your Health, Your Choices, Whose Decision***, was to enable the citizens of New Jersey to deal with that question head on so that a generally accepted rationale combining our society's ethical values and budget priorities might emerge. In this way, it would become possible for New Jersey to appropriate money authorized for health care in ways that respect the expressed values of its citizens in preference to the priorities of the courts or government agencies, especially where there is an obvious conflict between the two.

SCIENTIFIC SAMPLING

A questionnaire, especially prepared and professionally designed for the use of the Citizens' Committee, was administered at the end of each meeting to ascertain the values and attitudes of participants. The information gathered is presented in this report.

Consisting of seven parts, and designed to cover such issues as responsibility for providing health care, the right to refuse or accept health care, the cost of health care, access to medical records, treatment of the incompetent, the questionnaire was also designed to control for such demographic variables as age, weight, smoker or non-smoker, education, marital status, medical history, medical insurance, religious affiliation, and income.

To further its educational interests, the Citizens' Committee used radio and television networks extensively to reach an even larger audience. Since April 1986, some thirty radio and television programs have helped to raise the level of awareness of these critical issues among the citizens of New Jersey.

The medical-ethical issues on which public opinion was sought in this survey are complex. For this reason, the Committee decided that greater justice would be done to the issues if the respondents had the opportunity to discuss them with their fellow citizens before completing the questionnaire. With the benefit of reflection and discussion afforded by participating in the Committee's educational forums, respondents would be in a position to provide their considered responses. This, of course, meant that respondents were self-selected in that they were willing to participate in what was a time-consuming process. Thus, the results as outlined in Chapter Two are projectable to those interested and presumably better informed people and not necessarily the population as a whole. It is, however, important to emphasize that the respondents do represent a cross-section of such interested people throughout New Jersey.

To counter the possible biased data derived from a self-selected sample, the Committee conducted a telephone survey of 403 New Jersey residents randomly selected. The findings of this survey are detailed in Chapter Two which also provides an analysis comparing these findings with those derived from the self-selected sample.

A CITIZEN'S RESPONSIBILITY

The approach of the Citizens' Committee is based on the conviction that citizens are responsible for their society. In this particular case, they are responsible for addressing the problems of health care systems which form an integral part of a humane society. It is, moreover, the conviction of the Committee that these problems are too important to be left to hospitals, physicians, government authorities, or the courts alone. Medical-ethical issues will receive more adequate attention when, together with the professionals, the users determine how health care systems can work to honor the values of individual autonomy, justice, dignity, compassion, and fairness, as well as medical benefit. The Citizens' Committee affirms the right and responsibility of citizens to insist that their ethical values and preferences shape health care policies relating to actual medical treatment and the allocation of resources. One major outcome of this broad-based discussion would be the determination of the boundaries of adequate health care to which every citizen might claim a right.

UPON NEUTRAL GROUND

Throughout the entire project, the Citizens' Committee has remained impartial. It is not a lobbying group for one particular issue, much less for one side of a particular issue.

The Committee believes that the most valuable contribution it can make is to provide a forum and framework for a broad-based public discussion without itself taking sides. Moreover, the Committee believes that this report, which it will present to the Governor and the Legislature, among others, will, as a result of its neutrality, be a balanced reflection of the opinions of the citizens of New Jersey.

A GROWING CONCERN FOR A GROWING CONCERN

The Citizens' Committee began in 1983 with five people. Today it numbers more than 300 people, serving as Trustees, Advisors, or Participating Associates and representing lay persons, doctors, nurses, hospital and nursing home administrators, lawyers, clergy, ethicists, educators, and home health care professionals. Besides the essential support of the personal commitment on the part of these members, the Committee is supported financially by a number of foundations and corporations, including The Edna and Jack Belasco Foundation, CIBA-GEIGY Corporation, The Fund for New Jersey, The Greenwall Foundation, Hoffmann-LaRoche, The Home Life-Charitable Trust, The Hyde and Watson Foundation, The JM Foundation, The Prudential Foundation, The Robert Wood Johnson Foundation, The Schultz Foundation, and The Warner Lambert Foundation.

Support from these foundations and corporations rests on two premises which they share with the Citizens' Committee — the need for an educated public and the need for the public voice to be heard.

The Citizens' Committee acknowledges that health care professionals and legislators must eventually lead the way in formulating public policies affecting the provision of health care, especially in a climate of rapidly changing medical technology and an accompanying climate of ethical complexity. But they should not presume to lead before they have heard loudly and clearly from the people for whom they provide medical care and for whom they legislate.

PUBLIC FORUMS

The allocation of limited resources, the use of high technology, questions about the quality of life, discussions of autonomy and living wills, as well as the withholding or termination of medical care are among the most controversial and pressing dilemmas confronting the health care system and American society. Throughout the country there is much public concern about the health care system because the decisions that are made in this arena have an impact on each of our lives. Fundamental disagreements exist over the distribution of scarce medical resources, such as organs donated for transplantation, and the ways in which to control rising medical costs.

The Citizens' Committee on Biomedical Ethics has provided a statewide educational forum so as to allow citizens to address these issues and becoming more informed

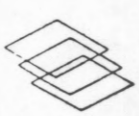
about their health choices. Prior to 1985, decisions were being made primarily by caregivers, hospital administrators, families, legislators, and the courts. These decisions were often being made without the aid of a clear social policy framework, and many times without adequate discussion and understanding of the alternatives. The Citizens' Committee believes that there is a need for the community to study these issues and develop guidelines within which health care choices and outcomes can receive more thoughtful consideration.

To achieve this goal, the Citizens' Committee held meetings in local churches, neighborhood centers, and service organizations, such as the Rotary Clubs, the American Association for University Women, and the National Council of Jewish Women, among others. Meetings were also held for professional groups such as the American Cancer Society, the New Jersey Lung Association, the New Jersey State Division on Aging, and the New Jersey Academy of Medicine. Medical schools, nursing schools, county colleges, high schools, and county law and medical societies also participated in this project.

The meetings were conducted in part in such a way that those attending could explore the issues carefully and from a variety of perspectives. Forthright discussion by participants was a most important objective. Volunteer facilitators had undergone group dynamics orientation sessions led by Dr. Arlene King of Montclair State College in New Jersey. A typical program included the showing of a video or the viewing of sociodrama which highlighted the biomedical issues under discussion. In most cases, a panel of professionals representing law, medicine, nursing, religion, and ethics was present to lend their expertise to the discussion. On some occasions, social workers, patient advocates, health administrators, and health economists participated. The participants were divided into small groups so that they had the personal experience of wrestling with the dilemmas, setting priorities and trying to work out equitable policies which would satisfy the preferences of diverse populations. This served to make participants aware of how complex the issues are and how difficult it can be to reach consensus. Each meeting closed with the administration of a questionnaire.

In summary, the public forums provided citizens with the rare opportunity to express their attitudes about the provision of health care while beginning to give shape to community based preferences for the quantity and quality of medical services to be provided.

The underlying purpose in conducting these meetings was to generate public conversation, not confrontation. The issues were debated openly with the intention of making reasonable and ethical decisions based on known and predictable information and alternatives.



30X

FROM PUBLIC OPINION TO PUBLIC JUDGMENT

As the report has already indicated, one of the most important goals of *Your Health, Your Choices, Whose Decision* was to measure public opinion on a range of biomedical-ethical issues. However, the goal was not set as an end in itself but as one of the essential steps required to bring public awareness to a level where the more difficult task of developing public judgment on these issues can begin.

In the following two chapters of this report, a careful analysis of the two statewide surveys conducted between 1985-88 is provided. Probably the most comprehensive measurement of public opinion in New Jersey on these issues, to date, the surveys will contribute substantially to a realistic, representative and informed resolution of the difficult ethical problems in contemporary medical care.

Chapter Two

Selected Public Survey

Between April 1985 and December 1987, the Citizens' Committee conducted some 300 seminars throughout the state. At the conclusion of each seminar, participants were asked to complete a self-administered questionnare. This chapter analyzes the data obtained from 2,247 completed questionnaires.

INTRODUCTION

Because of the comprehensive nature of the survey and the consequent length of the questionnaire, the instrument was broken down into seven (7) components, six (6) substantive areas and one (1) section on respondent demographics. Each respondent was asked to fill out from one (1) to three (3) substantive sections and a demographics section. The actual number of people responding to each section was:

Section	Subject Matter	Number of Respondents
A	Who Has Responsibilty to Protect and Maintain Life	2216
B	Access to Information and Records	726
C	Who Should Make Decisions for the Incapacitated	817
F	Refusing Care	754
D	Who is Responsible for Paying for Medical Care	1084
E	Deciding Who Gets Care, and When Society Should Pay For Care	1062
Z	Demographics	2247

All tables in this chapter represent abbreviated versions of the full set of cross-tabulations.

OVERVIEW

There are two themes present throughout these data. The first, and the dominant one, is an overriding preference to make one's own medical decisions. Whether it is the very grave matter of the medical treatment of the critically ill, or less onerous issues, such as access to medical records, respondents consistently opted for as much personal control as possible. And even in medical conditions, such as a coma, when they cannot exercise this kind of control directly, respondents want members of the immediate family to exercise it on their behalf. Ideally, respondents want surrogates to make decisions which they, the respondents, have expressed through a living will or a power of attorney.

Their preference to make their own medical decisions does not, however, mean that respondents do not recognize obligations which society may have, in particular, to assist the financing of medical care. Hence the second theme, which this survey has detected, is the desirability of government involvement in paying for extraordinary medical care.

WHO HAS RESPONSIBILITY

In this section, respondents were asked to indicate who, primarily, and then secondarily, should be responsible for protecting and maintaining the lives of six (6) different classes of people.

Assignment of primary responsibility was clearly divided into two general groups. Included in the first group, which is represented by those mentally able to make their own decision, were the respondents themselves, those over eighty (80) years of age, and those suffering from severe physical disability. Respondents say that individuals in any one of these three categories should have primary responsibility for protecting and maintaining their lives. After the individual, members of his immediate family are viewed as having the greatest responsibility to maintain and protect the life of that individual, Here, the elderly were something of an exception in that respondents assigned to them primary responsibility for their own lives or gave them none of the responsibility.

Included in the second group were those under twelve (12) years of age, those in a coma, and, indicatively, those suffering from severe depression.

Overall, while very few respondents think of doctors as having the primary responsibility for the first group, about half saw the doctor as sharing responsibility with the individual and the immediate family. However, some two thirds (⅔) of the respondents say that doctors share responsibility for those included in the second group.

Regardless of the circumstances, about one (1) in ten (10) respondents sees God as having the primary responsibility and about one fourth (¼) see God as sharing the responsibility. In a pattern that repeats itself throughout these results, this willingness to assign the responsibility to God is a function of how often someone attends religious service rather than a nominal religious affiliation. Respondents who say they attend some religious service at least once a week are about ten percent more likely than other respondents to assign responsibility to God in any given circumstance.

	—Primary Responsibility—				—Any Responsibility—			
	Self	Family	Doctor	God	Self	Family	Doctor	God
Own Life	77%	6%	1%	15%	92%	90%	42%	29%
Person over 80	60	19	2	13	71	85	47	25
Physical Disability	53	23	6	11	62	88	51	22
Severe Depression	16	57	10	10	25	90	67	20
Person under 12	8	76	2	11	17	95	64	28
In a Coma	7	63	8	14	10	89	67	30

RESPONSIBILITY FOR HEALTH EDUCATION

Individuals accept that they are primarily responsible for their own health education. About three (3) out of five (5) people think that they are primarily responsible, while four (4) out of five (5) feel they at least share the responsibility. The person with the next greatest responsibility is the individual's doctor, with three (3) out of four (4) respondents saying that their doctor at least shares the responsibility. One (1) in ten (10) thinks society as a whole has the primary responsibility and more than half feel society is at least partly responsible for health education.

ACCESS TO RECORDS

Almost everyone thinks that his immediate family should have access to his medical records if he should become mentally unable to function. Lawyers are the only others for whom there is strong support to grant access to records in cases of mental incompetence. Slightly less than half of the respondents would allow their lawyer to have access to their medical records under such circumstances.

There is substantial opposition to anyone seeing an individual's medical records without that individual's permission. Indeed so deep-seated is this opposition that one (1) out of every four (4) respondents say that, except for the doctor's diagnosis, he would deny access to any other part of his records even when the purpose is to get a second opinion. While, in general, those with less education are the most resistant to the release of medical records, among those with college degrees:

- About half would deny government access to the doctor's diagnosis without an individual's permission, even for purposes of monitoring the safety of the medical system.
- Less than half would allow government access to anything except the doctor's diagnosis in order to "educate doctors on the best ways to diagnose and treat illness."
- Less than half would allow insurance companies access to the nature of medical treatment in order to monitor and control insurance claims.

It is quite possible that many of the respondents would make their own records available in a wide variety of situations. What was asked in these questions is whether government and various other groups should be able to see such records without the respondent's permission. Thus the answers reflect more the issues of privacy, and may or may not reflect any personal unwillingness to cooperate.

	Your Statement of Symptoms	Doctor's Diagnosis	Doctor's Estimate of Benefits	The Outcome
Yourself for Second Opinion	65%	86%	75%	64%
Courts and lawyers to handle malpractice problems	34	53	44	50
Educate health care professionals	27	52	34	44
Government to monitor safety	22	46	36	44
Insurance companies to monitor claims	17	47	39	34
Government to monitor costs	17	40	34	38

CONTROLLING TREATMENT

Ideally, respondents wish to control their own treatment.

> Only three percent of all respondents say that the state "should not allow people to designate in writing who should make medical decisions for them before they become mentally disabled."

Indeed 20 percent say the state should require people to make such written designations, while the overwhelming majority feel that states should at least allow people to do so.

This desire for control is very real. One (1) out of five (5) respondents has authorized someone to have power of attorney, and despite its non-binding legal status, one (1) out of eight (8) respondents says he has a living will. This proportion increases markedly among those respondents over 65 years of age.

	Total	15-29	30-49	50-64	65 +
Have Power of Attorney	20%	12%	112%	20%	46%
Have Living Will	14	10	9	12	35
Don't have Living Will but have thought about it	52	39	61	62	46

Moreover, assuming that a living will is recognized in statute law, large majorities would want such instruments to have very broad powers:

- 86% would allow the inclusion of instructions on using "heroic measures" for patients who are declared brain dead
- 75% would allow the inclusion of instructions on organ donation

- 72% would allow the inclusion of instructions obliging a doctor to release patients from hospital even if that would mean an earlier death
- 71% would allow the inclusion of instructions on the use of addictive pain relievers
- 68% would allow the inclusion of instructions on withholding food and water when patients are in a coma
- 63% would allow the inclusion of instructions on the use of "research" therapies

REFUSING CARE

Respondents were given four (4) statements about their right to end their own life. In addition, a significant number of respondents volunteered a fifth statement on the difference between taking one's own life and refusing "heroic measures." On this issue, there are very substantial differences among respondents when viewed on the basis of their nominal religious preference and the frequency with which they attend religious service.

"I should have the right to end my own life."

		Church weekly or more		Church less than weekly	
	Total	Cath	Prot	Cath	Prot
Whenever I wish	24%	17%	10%	23%	31%
If in pain, even if not terminal	14	7	20	14	15
Only if suffering from terminal illness	42	29	54	47	58
Shouldn't, but no Heroic Measures either (Volunteered)	11	22	10	6	6
Shouldn't under any circumstances	14	26	17	13	0

Note: Numbers come to more than 100% because some people volunteered a second answer.

In a similar question on procedures to be followed before a "person with a painful or terminal illness" would be allowed to take his own life, slightly under one third (⅓) of all respondents say, "that person should be prevented from committing suicide." Overall, about two (2) in five (5) Catholics, one (1) in four (4) Protestants and one (1) in eight (8) Jews take this position. Those who attend religious services once a week or more are more likely to take a position against suicide.

The decision to refuse care is essentially a personal one, albeit a decision people think should be shared with members of the family and, to a lesser degree, with doctors.

Three quarters (¾) of all respondents feel that an adult has the final responsibility to decide whether he may be allowed to die or not. About half (½) the respondents take the same view in the case of teenagers.

When respondents were asked, "Who should have the final responsibility to decide whether each of the following should be allowed to die or not," they responded as follows:

	Child under 13	Teenager under 18	Adult over 18	Mentally Competent over 80
No one	13%	9%	7%	8%
Person himself	30	49	76	72
Immediate family	76	70	48	42
Doctor and/or doctors	41	46	39	35
Lawyer	4	4	4	4

WHO PAYS FOR MEDICAL COSTS

The preferred degree to which society should pay for medical care depends in part on the nature of the illness. For each of eight (8) different medical needs, respondents were asked if medical care should be provided free by society, paid for jointly by the recipient and society or paid totally by the recipient. In each case, this was done for five (5) different age categories of people.

For all eight (8) categories of medical care, the proportion of respondents preferring society to pay all of the costs varied systematically according to the age group of the individual needing the care. In particular, with a single minor exception to be noted below, respondents are:

- most willing that society pay for those under 13
- next most willing that society pay for those over 70
- next most willing that society pay for those between 13 and 25
- next most willing that society pay for those between 55 and 70
- least willing that society pay for those between 25 and 55

The sole exception to this pattern is that respondents are slightly more willing for society to pay for all the prescription drug costs for those over 70 than for those under 13.

Because of this consistent pattern, it is possible to rank the eight (8) conditions by willingness that society pay all of the costs as follows:

Most Willing — Vaccinations
The next two are virtually equal — Kidney dialysis
Organ transplants

The next four are virtually equal — Nursing home for the terminally ill
Coronary bypass surgery
Cancer treatments
Hearing aids

Least Willing — Prescriptions

In general, the largest single group of respondents thinks that medical costs should be shared between individuals and society. The one notable exception is that group of people who have the greatest medical needs, those over 70 years of age. Although not shown in the table, young people are more willing than any other group that society pay all of the costs for the medical care of their elders. Specifically 57 percent of those under 30 think that society should pay all the costs for those over 70, but only 33 percent of those over 65 share this view.

	Society Pay All	Society & Individual Share	Individual Pay All
For Fetus or Unborn Child	22%	42%	26%
Any person up to age 13	21	47	22
Between age 13 and 25	13	54	22
Between age 25 and 55	12	50	28
Between age 55 and 70	23	53	14
Age 71 or over	41	42	7

Note: No opinion and other answers omitted.

The feeling that society should at least share in the costs of most medical care breaks down only for quite wealthy people. For instance, only 13 percent of respondents think that a family with an income of between $50,000 and $99,999 should be responsible for all of their own medical expenses. In part, this feeling probably reflects a lack of understanding of the national distribution of family income, and a corresponding assignment of middle class status to a very wide range of Americans. The real situation is quite different. Only about one (1) American household in ten (10) has an income of over $50,000. Thus, as a practical matter, these respondents want society to share in paying almost everyone's medical costs.

Respondents were also asked at what level a family's responsibility to pay for "catastrophic or long term illness" should stop? Only about 10 percent feel that a family should be required to go beyond using current income and begin to draw on its savings.

39X

Chapter Three

General Public Survey

During the month of February 1988, the Citizens' Committee conducted a telephone survey of a randomly selected sample of 403 New Jersey citizens. Each interview lasted approximately 20 minutes and was conducted from a central interviewing facility under professional supervision. Experienced interviewers were used and all interviewers were given briefings on the specifics of the questionnaire used. This chapter analyzes the data obtained from the survey.

INTRODUCTION

In the previous chapter, we discussed the results of over 2200 self-administered questionnaires which were filled out by individuals after they had participated in a session that included a film presentation and group discussion. As a supplement to this intensive effort with people who, to a considerable degree, were self-selected (and often activists), it was felt that a scaled-down telephone interview with a randomly selected and projectable sample of New Jersey households would round out our understanding of current attitudes of New Jersey citizens on the same bio-medical-ethical issues.

OVERVIEW

In large measure, these data confirm the fact that despite the special nature of the publics interviewed by means of the self-administered questionnaire, the sample was in many respects a representative cross-section of New Jersey adults. As a result, this projectable sample clearly reiterates the main themes developed in the previous chapter.

Again, the first and dominant theme to emerge is an overriding desire to make one's own medical decisions. If anything, the general public is even stronger in their concern for personal control of everything, from decisions to continue treating the critically ill to the privacy of medical records. And, just like the special publics discussed in the previous chapter, the general public emphasizes the need for society to share in paying for extraordinary medical care.

METHODOLOGY

Questionnaire

The interview covered a range of issues confronting all adults. They are as follows:

Access to Information and Records

Who Should Make Decisions for the Incapacitated

The Right to End One's Own Life

Refusing Medical Care

When Should Society Pay for Care

Tabulations and analysis

All tables in this chapter represent quite abbreviated versions of the full set of cross-tabulations. Where applicable, comparable figures for the special publics are also shown.

Weighting

All data from each of the four (4) groups of respondents were weighted to reflect known demographics in the State of New Jersey. Respondents were weighted to known proportions by sex and age. These weighted ratios were then projected to the known population of adults in the State of New Jersey of 5.7 million.

ACCESS TO MEDICAL RECORDS

For each of seven (7) different circumstances, respondents were asked if they would approve or disapprove of access to their medical records without their permission. About 10 percent of the population disapprove in all seven (7) cases and about 15 percent approve in all seven (7) cases. The attitudes of the balance of the population depended on who would see their records and for what purpose. In general, to the degree there were any differences, younger people as well as people with lower incomes are more willing to approve of access to their medical records.

The greatest level of disapproval is registered against "employers having the medical records of people they want to hire." Conversely, aside from the 10 percent who disapprove regardless of the purposes or circumstances, only about a quarter (¼) of the respondents disapprove of granting access to "a government agency to keep track of diseases and potential causes of epidemics." In general, the greatest disapproval is registered against access for the two (2) exclusively private sector groups (employers and insurance companies); the next greatest disapproval is registered against access for mixed or non-profit groups (lawyers and courts and medical researchers). The greatest approval is registered for access by government for three (3) purposes: tracking costs, supervising quality and safety, and tracking disease or epidemics. Thus it would appear that in this area of access to records, the suspicion of government is much lower than it is in a number of other areas. However, later in this chapter, it becomes clear that people distinguish sharply between government use of their records for general societal purposes, such as tracking costs or epidemics, and government playing a direct role in their personal medical decisions.

While some individuals deviate from the pattern or sequence of levels of approval described above, there is considerable consistency in the relative degree to which respondents disapprove of access under the variety of circumstances tested. Indeed, the ranking of levels of approval is almost the same for all of the approximately 40 sub-groups considered. Perhaps the greatest deviation is to be found among young people (age 18-29) as shown in the following chart.

(continued)

Percent disapproving (somewhat or strongly) under each circumstance

	Total	18-29	30-59	60 +
Number of respondents	403	105	205	89
An employer of a job applicant	63%	49%	70%	66%
Insurance companies to keep track of claims	57	52	64	47
Lawyers and courts to monitor malpractice	4	44	60	54
Researchers working to improve health care	47	29	55	51
Government to track costs	43	37	52	30
State to supervise quality and safety	40	24	48	39
Government to track diseases and potential epidemics	32	27	35	30

HEALTH EDUCATION

"The primary responsibility for educating you about how to maintain and improve your health" is perceived by 73 percent of the general public to rest with the individual. After that, 14 percent of the general public believes that responsibility rests with "your doctor."

WHO SHOULD CONTROL TREATMENT

Without exception, respondents say that members of their immediate family would be their first choice to "make a decision about your medical treatment if you were mentally or physically incapacitated." Overall, 95 percent of the general public of New Jersey feel that members of their immediate family can be trusted to make a decison about medical treatment on their behalf. Similarly, 87 percent of the general public feel that their family should "have the final authority to make decisions when they [the respondents] are in a coma and not able to decide for themselves whether to have 'heroic measures' to keep them alive."

Conversely, only three (3) percent of the public think they could trust a government agency to make medical decisions for them, and 94 percent of the general public explicitly do not think that state and government agencies can be trusted to make such a decision. Less than two (2) percent would like to see even specially designated government agencies with the authority to make final decisions about medical treatment.

Respondents are willing to allow a variety of other people to participate in making medical decisions. For instance, 55 percent say that their doctor should be involved in decisions about heroic measures, but only six (6) percent want the doctor to have the authority to make a final decision. Similarly, 45 percent say they trust their best friend to make a medical decision on their behalf; 32 percent say they trust their minister or rabbi, while 23 percent say they trust their lawyer to make a medical decision on their behalf.

POWER OF ATTORNEY AND LIVING WILLS

30 percent of the sample population claims to have signed a "Power of Attorney" document. Of these, 46 percent — the largest percentage — are aged 60 years and older.

Nine (9) percent of the sample population, projected to roughly one half (½) million individuals, claim to have signed a "living will" describing how they wish to be treated medically when they cannot decide for themselves, and another 16 percent say they have thought about such wills. This relatively high number of currently unenforceable documents obviously reflects in part the preference for the family to have final authority to make medical decisions.

Making decisions about heroic measures

	Having a Say	Final Authority
Immediate family	94%	87%
Person's doctor	55	6
Other relatives	20	1
Person's lawyer	12	
Hospital or nursing home ethics committee	9	
State agency	8	1
State court	7	1

Which of these applies?

	Total	18-39	40-59	60+
Given a Power of Attorney	30%	20%	34%	46%
Heard of a Living Will	67	60	75	72
Thought about but don't have a Living Will	16	15	16	19
Have a Living Will	9	4	12	15

THE RIGHT TO END ONE'S OWN LIFE

Respondents were asked if there are any circumstances in which a person should be allowed to take his own life. If the respondent said it "depends on the circumstances," he was presented with a series of four (4) specific situations and asked whether suicide might be an acceptable alternative to each.

Overall, New Jerseyans are roughly evenly split on whether a person should "have the right to end their own life."

52 percent of the projected general public of New Jersey either feel an individual should be allowed to take his own life

"whenever they wished" (11%), or

say "it depends" and then found that at least one of the four (4) situations presented justified taking one's own life (41%).

Conversely, 48 percent of the general projected adult population of New Jersey feel either that an individual should not be allowed to take his own life

"under any circumstances" (35%), or

say "it depends" and then did not feel any of the four (4) situations presented justified taking one's own life (13%).

Since the circumstances presented, including suffering from a terminal illness, are the most significant justifications normally used to justify ending one's life, it would appear that there are in reality no significant circumstances under which this 13 percent would approve of ending one's own life.

Those who feel that people under some circumstance have a right to end their own life were also asked if a doctor should be allowed to prescribe medication to secure suicide. Twenty-seven percent of adults in New Jersey approve of a doctor prescribing medication of this kind, while nine (9) percent say they do not know.

Overall, there is little difference between nominal Catholics and white Protestants on the question of suicide. Forty percent of Catholics and 35 percent of white Protestants say an individual should not take his own life "under any circumstances." However, there is substantial difference in views as a function of how often the respondent goes to church. Those who are regular church goers (once a week or more) are much more likely to oppose an individual's 'right' to take his own life than those who claim a nominal religious affiliation but attend religious services less frequently. Fifty-three percent of all church goers believe that "under no circumstances" should an individual be allowed to take his own life. This figure drops significantly to about 24 percent for those who go to church less often than weekly.

Thus it is the frequency with which respondents attend religious services, rather than their nominal religious affiliation, that is the main predictor determining the individual's attitudes about taking his own life.

"A person has the right to take their own life"

	Total	Catholic	White Protestant	Church Attendance Weekly Plus	Church Attendance Less
Number of respondents	403	191	143	147	197
Whenever they wish	11%	9%	9%	6%	10%
At least 1 of 4 Circumstances	41	40	39	27	51
Suffering terminal illness	37	37	35	26	46
In severe pain	16	12	17	7	21
To avoid nursing home	14	15	11	9	17
If they are sick and alone	12	12	9	8	14
Said depends on circumstance, but rejected all 4 circumstances presented	13	11	16	13	14
Under no circumstances	35	40	35	53	24

Note: Samples are too small for separate analysis of Jews, Black Protestants, and those claiming no religion. However, the limited data for these groups follows the same pattern as that shown in the chart above.

45X

REFUSING CARE

In general, respondents are much more willing to accept the refusal of medical care than they are prepared to sanction taking one's own life. Overall, 71 percent of the projected population of New Jersey found at least one (1) set of circumstances in which they feel an individual has the right to refuse medical care even if it means that death will occur. Note that only 52 percent could find circumstances in which they felt an individual had the right to take his own life.

Not surprisingly, five (5) out of six (6) of those respondents who advocated the right to take one's own life would also allow the refusal of medical care. What is most significant, however, is that even among those who do not acknowledge the right to take one's own life, MORE THAN HALF would allow the refusal of medical care.

Equally significant is the fact that medical care is not being narrowly defined here. For example, almost half (48 percent) say that feeding through a tube is part of medical care and could therefore be refused.

A number of factors seem to contribute to this greater tolerance for refusing medical care. First, there is little difference between Catholics and white Protestants in the approval they extend to taking one's own life. What slight difference there is, indicates that Catholics are five (5) percentage points more likely to say that there are no circumstances that would allow an individual to take his own life.

Second, Catholics are six (6) percentage points more likely than white Protestants to find circumstances in which the refusal of medical care is legitimate. There is, as a consequence, a relative swing of some 11 percent (5 + 6) which causes a significant move in the overall results.

Finally, the difference between those who attend religious services regularly and those who do not is less clear, because many more regular church goers accept at least some circumstances which justify refusing medical care. The number of regular church goers who say that "under no circumstances" should medical care be refused is 26 percent. This figure drops to 13 percent for those who attend church less regularly.

(continued)

Circumstances in which a person has a right to refuse medical care, even if it means that he or she will die earlier.

	Total	Catholic	White Protestant	Church Attendance Weekly Plus	Church Attendance Less
Number of respondents	403	191	143	147	197
At least 1 of 3 circumstances	71%	71%	65%	61%	75%
In severe pain	50	47	49	41	52
If they feel it is too costly	33	31	30	25	34
If there is no one to look after them	32	31	28	23	35
Said depends on circumstance but no to all 3 circumstances	13	11	14	13	13
Under no circumstances	17	17	21	26	13

Note: Samples are too small for separate analysis of Jews, black Protestants, and those claiming no religion. Nevertheless, the limited data for these groups follows the same pattern as that shown in the chart above.

WHEN SHOULD SOCIETY PAY FOR MEDICAL CARE

Respondents were given a choice to provide medical care for various medical conditions so that it was provided free to everyone (that is, paid by the government); or it was provided with the cost shared between the patient and the government; or it was provided with the cost paid entirely by the patient. The following chart shows the tendencies of the sample as a whole.

For the first six (6) of the 11 conditions presented, a quite similar pattern of responses emerged, albeit with some significant differences in actual numbers. In each case, only a small fraction (between 12 percent and 15 percent) of the respondents want the individual to pay the total cost, with 80 percent or so wanting society to pay at least part of the cost. One of the most interesting findings here relates to AIDS. In our opinion, the preference of an overwhelming majority of a projectable sample of New Jersey adults for society to pay all or part of the cost of treatment of AIDS suggests that people are compassionate in their attitudes towards people with AIDS. The next three (3) conditions presented to respondents exhibit a different pattern of responses. It is perhaps surprising that coronary bypass is not grouped with the first six (6) conditions. Instead, a significantly larger number of respondents think that coronary bypass should be paid for totally by the individual. Vaccinations, on the other hand, are the only condition to show a clearly bipolar result with relatively few respondents favoring a shared cost arrangement.

The last two (2), rather generic and presumably less costly conditions were not, for the most part, viewed by respondents as suitable candidates for complete government subsidies. It should be noted that this is the case regardless of the age of the respondent. For example, older people (60 +) are only slightly more likely to support full government subsidies for hearing aids and prescriptions.

Q16. Another issue of medical care concerns who will pay for medical care when it is very expensive. For each of the following, please tell me whether you think it should be provided free to everyone, partially paid for by the patient, or totally paid for by the patient either through insurance or out of his own money.

	Free to Everyone	Part govt.- Part Indiv.	Totally Individual	Don't Know
Nursing home care for people with Alzheimer's, etc.	53%	31%	13%	3%
Nursing home care for terminally ill patients	49	36	12	3
Treatment for AIDS	46	33	12	9
Kidney dialysis machines	45	36	13	6
Cancer treatments	41	40	15	4
Organ transplants	37	40	14	9
Treatment for drug abuse or alcoholism	28	31	37	4
Coronary bypass surgery	24	45	25	6
Vaccinations	40	18	38	4
Hearing aids	19	34	44	3
Prescriptions	17	39	41	3

RECOMMENDATIONS

In presenting this final report, the Citizens' Committee feels it is appropriate to make five (5) recommendations. Three (3) recommendations encompass a number of issues on which there is clear public consensus requiring immediate and effective action by the New Jersey State Legislature. Two (2) recommendations encompass an agenda designed to consolidate the efforts of the Citizens' Committee to provide a public forum, open to all New Jersey citizens, in which they can be informed about biomedical ethics and through which to exercise a timely influence on public policy for and legislation of, biomedical ethical issues.

The recommendations are as follows:

1. That legislation be enacted for the uniform use of living wills and durable power of attorney.

2. That legislation be enacted to provide broad guidelines for the treatment of the terminally ill, including guidelines on the application, withholding or withdrawing of such treatment, and on the responsibilities and obligations of surrogate decision-makers acting on behalf of incompetent patients.

3. That public policy be drawn up to recognize the individual as the one person with final responsibility to make decisions about his own health care without unreasonable interference from other individuals or government agencies.

4. That a statewide Health Decisions Assembly, organized on a grass-roots basis, be established to meet bi-annually to monitor health issues and make formal recommendations on biomedical ethical issues to the Legislature, public policy makers and professional health care providers.

5. That a major educational initiative be launched in conjunction with the schools, colleges, and universities to secure a public informed about biomedical ethics, health care for an aging society and the medical and social needs required for the proper care of AIDS patients.

COLLABORATING ORGANIZATIONS

Academy of Medicine
Alzheimer's Disease Fund of Westfield
American Association of Medical Assistants
American Association of University Women
Association of Diploma Schools of Nursing
AT&T
American Cancer Society
Barringer High School, Newark
Bergen Community College
Bergen-Passaic Health Systems Agency
Bridgeton Hospital
Brookdale Community College
Central Jersey Health Planning Council
Community Health Law Project, East Orange
Dwight-Englewood High School, Englewood
Dover General Hospital
Drew University, Madison
Edison Estates Rehabilitation Center
Ethical Culture Society, Teaneck and Maplewood
Executive Women Association
Family Physicians
Ft. Dix and Ft. Monmouth - U.S. Army Chaplain's School
Georgian Court College, Lakewood
Gill/St. Bernard's School, Bernardsville
Hackensack Hospice/Center for Health Volunteers
The Hastings Center
Holy Name Hospital, Teaneck
Home Health Agency Assembly of New Jersey
Honorary Gerontological Society
Human Genetics Association of New Jersey, Inc.
Humanists of North Jersey
Hunterdon County Advisory Council
Hunterdon Medical Center
International Ladies Garment Workers' Union
JFK Medical Center, Edison
Jersey City State College
Jewish Home and Rehabilitation Center
Journalism Resources Institute, Rutgers University
Leadership Council
Madison High School, Madison
Medical Librarians Association
Medical Sciences Learning Center, Freehold Regional High School
Middlesex County College
Monmouth County Library
Morris County School Nurses Association
Mt. Sinai Scholars, New York City
Mountainside Hospital School of Nursing
Muhlenberg Hospital, Plainfield
National Association of Social Workers
National Council of Jewish Women
National Gerontological Honor Society
New Jersey Business Group on Health
New Jersey Chapter, National Conference of Christians and Jews
New Jersey Committee on the Humanities
New Jersey Council of Churches
New Jersey Divisions on Aging
New Jersey Governor's School
New Jersey Hospice Organization
New Jersey Hospital Administrators
New Jersey Hospital Association
New Jersey Lung Association
New Jersey Medical Society
New Jersey Regional Hadassah
New Jersey Society for Nursing Service Administrators
North Central Clinic of Newark
Oak Knoll School, Summit
Ocean County College
Older Women's League of New Jersey
Orange Memorial Hospital
Overlook Hospital, Summit
Passaic County Community College
Patient Advocacy Organization
Princeton Memorial Association
Princeton Research Forum
Princeton Theological Seminary
Protective Services Agency
The Prudential Insurance Company of America
Ramapo College
Regional Health Planning Councils
Rider College
Rutgers University School of Social Work
Rutherford School District
St. Michael's Medical Center
St. Peter's Medical Center
Shore Memorial Hospital
Somerset County Medical Center
Southeast Center for Independent Living, Englewood
Stockton State College
Trenton State College
UMDNJ
Union Camp Corporation
Valley Hospital
Veterans Administration Hospital, East Orange
West Bergen Mental Health Center
William Paterson College
Woodrow Wilson School for International and Public Affairs

A CITIZEN'S RESPONSIBILITY

The approach of the Citizens' Committee is based on the conviction that citizens are responsible for their society. In this particular case, they are responsible for addressing the problems of health care systems which form an integral part of a humane society. It is, moreover, the conviction of the Committee that these problems are too important to be left to hospitals, physicians, government authorities, or the courts alone. Medical-ethical issues will receive more adequate attention when, together with the professionals, the users determine how health care systems can work to honor the values of individual autonomy, justice, dignity, compassion, and fairness, as well as medical benefit. The Citizens' Committee affirms the right and responsibility of citizens to insist that their ethical values and preferences shape health care policies relating to actual medical treatment and the allocation of resources. One major outcome of this broad-based discussion would be the determination of the boundaries of adequate health care to which every citizen might claim a right.

The Citizens' Committee on Biomedical Ethics, Inc.

VOL 5, NO 1

Newsletter

JUNE 1990

Something New . . .

This new format for our Newsletter will give us an opportunity to communicate more frequently and keep you informed about our various endeavors. Since **you** are the Citizens' Committee, we encourage **you**, our members, to contribute **your** ideas and share **your** concerns by submitting letters, articles and news items of special interest. Please let us hear from you. (Please note our new address!)

Mary

In the past twelve months the activities of The Citizens' Committee on Biomedical Ethics have continued along lines already established, while expanding into new and related areas. Several of the new initiatives hold significant promise:

Ombudsman for the Institutionalized Elderly

Concerned by the overreach of regulations proposed by the Ombudsman affecting end-of-life health decisions by or on behalf of nursing home patients, we organized a coalition of health professionals to consider this serious problem. The Task Force appointed by The Citizens' Committee studied the regulations and their probable repercussions, and its three reports have had significant impact in moderating what the Ombudsman now proposes to do. The matter is not yet completed to our satisfaction.

Survey of Beneficial Care/Quality of Life

Jointly with the Center for Health Ethics and Policy of the University of Colorado, we are conducting a two-state project to develop a standard measure for evaluting patients' attitudes about quality of life based on outcomes of treatment.

Ethics and Values Debating Programs

In this pilot program, running concurrently at Central High School in Newark and Montclair High School, we are helping upper grade students to develop their ethical thinking; the enthusiastic response of students and faculty is astonishing. We plan to seek support for replicating this program in schools throughout the State, especially in inner city areas.

Universal (National) Health Care

The Committee has joined the national debate on this issue, which has gained new attention as the costs of medical insurance plans have escalated. In keeping with our mission for citizen exploration of health care problems, we aim to point out the pros and cons, and to call attention to the pitfalls in any headlong rush to a nationwide "solution."

Federation for Applied Social Ethics

The Citizens' Committee convened a meeting of New Jersey college presidents and their deputies to discuss our concept for a federation of ethicists from all disciplines. A steering committee is poised to pursue the concept which received the heartiest endorsement of those who attended.

New Jersey Expansion

A South Jersey Chapter of the Citizens' Committee, based in Moorestown, has been organized. It will conduct its own programs under our aegis. A North Jersey Chapter, which will embrace the northern tier of counties, is in the process of being organized.

New York and Delaware

The Committee has done extensive consultation with interested individuals in New York, who have now organized a Citizens' Committee on Health Care Decisions, New York. On April 30, 1990 we met with a group at the University of Delaware and expect to help it, too, in forming a committee, perhaps in conjunction with citizens in greater Philadelphia.

Of Special Interest . . .

CRUZAN DECISION DOES NOT AFFECT NEW JERSEY LAW

On Monday, June 25 the US Supreme Court issued its decision in the Nancy Cruzan Right-to-Die case. Nancy's parents had petitioned the Court of Missouri and the United States Supreme Court for an order allowing them to remove life-sustaining support for their unconscious daughter who had been diagnosed to be in a persistent vegetative state.

The US Supreme Court ruled that the Missouri Statute, which required "clear and convincing proof" that a person would have wanted life-sustaining treatment withdrawn, does not violate Nancy's constitutional rights. In upholding Missouri's Statute, the Court concluded that the State could apply the clear and convincing evidence standard when a guardian seeks to discontinue nutrition and hydration for anyone diagnosed to be in a persistent vegetative state.

The US Supreme Court's ruling applies only to people residing in Missouri. It has no effect in New Jersey. New Jersey Supreme Court rulings since the Quinlan decision in 1976 have held that life-sustaining treatment can be removed from patients like Nancy in accordance with procedures outlined by the Court. New Jersey has recognized the rights of parents and others to be surrogate decision-makers for patients and to allow the patients' prior decisions to govern whether life-sustaining treatment should or should not be terminated. New Jersey residents can write living wills which express their desires regarding medical treatment in the event they become incompetent. At this time there is no standardized living will form. The New Jersey Legislature is considering a statute which would place specific requirements with regard to the substance and form of living wills. **However, until this legislation is enacted, any form of living will is admissible as evidence of a person's intent regarding their medical care or non-treatment.**

Coming Up . . .

American Health Decisions
Assembly For Health Decisions
Chaplains' Conference Series
Citizens' Committee Coalition - Ombudsman Task Force
Legislative Seminars
Institutional Ethics Committees - Development and Education
Living Will Workshops - Corporate, Community and Education
Membership Development
UMDNJ — Joint Education Training Programs

The Citizens' Committee on Biomedical Ethics, Inc.
Oakes Outreach Center
120 Morris Avenue
Summit, N.J. 07901-3948
(908) 277-3858

Tough Medical Choices: Letting the People Decide

By SANDRA BLAKESLEE

In grange halls, community clubs and churches across the country, thousands of ordinary citizens are getting together to discuss two of the thorniest issues in public policy: What kind of health care should Americans have, and who should pay for it?

In most cases, the efforts are aimed at persuading public officials to take some kind of action. In Colorado, for example, 30,000 people took part in a two-year program to elicit the public's views on health care. One result was a law allowing terminally ill people to refuse food and water.

In Orange County, Calif., a grass-roots health discussion group persuaded county officials to increase spending on prenatal care for the poor.

And in Oregon, the Legislature relied on a grass-roots organization for information and support when it took steps to reduce the medical care it provided to poor people while expanding the number of people covered.

Letting Society Decide

Formal discussions of these big bioethical questions "almost always end with the refrain that society must decide," said Michael Garland, an associate professor of community medicine and medical ethics at the Oregon Health Sciences University in Portland and a founder of Oregon Health Decisions, the umbrella group that pushed the Legislature to act. "But if society is to decide, there has to be a forum for discussing the issues."

At a meeting in Chicago last October, 10 state groups formed American Health Decisions, whose goal is to pressure Congress to tackle health care issues, said Robert Slater, a Vermont doctor who is a leader of the organization.

While the efforts vary from state to state, they share common traits. Often, organizers became interested in health care issues because they or someone in their family had a bad experience as a patient, like costly treatment they did not want. These volunteer organizers form a small central staff and raise money from foundations or private donations. Usually, they turn to experts in medical ethics for advice and training; then they tap into social organizations like service clubs and religious groups. A volunteer attends a meeting of a local group. The volunteers may show a videotape or guide a group discussion.

Topics vary, from the kind of medical services states should provide to whether terminally ill people have the right to refuse treatment. Participants may be asked to pretend they are officials deciding such matters.

Pent-Up Desire to be Heard

At the end of a meeting, the volunteer often asks participants to answer a questionnaire about their views. Typically, the state groups use the information to lobby their legislatures.

Groups have been formed in Arizona, Florida, Georgia, Massachusetts, New Jersey, Tennessee and Vermont, as well as California, Colorado and Oregon. Organizing efforts are under way in New Mexico, New York and Ohio. Although the groups are not active now, there have been such organizations in Hawaii, Idaho, Illinois, Iowa, Maine, North Carolina and Wisconsin.

The movement "is responding to an abiding, widespread and pent-up desire on the part of the public at large to make their voices heard in shaping future directions of medicine and health care," said Bruce Jennings, an associate for policy studies at the Hastings Center, a leading bioethics think tank in Briarcliff Manor, N.Y.

Participants are from all walks of life, Mr. Garland said. Physicians and other health care workers often come to the meetings, he said, because they are frustrated by their inability to provide basic care to everyone who needs it.

At a recent meeting at a church in Bristol, Vt., one woman spoke bitterly of her father's slow death from cancer. He was "paying $60 a day to swallow 17 different kinds of pills," she said, adding, "What nobody stopped to ask was what kind of a life they were saving."

Organizers of the various state-based movements say a major goal is to help state legislators make tough policy decisions about scarce resources. Politicians will not make these choices until they feel that public opinion is behind them, said Mr. Garland.

At the meeting in Vermont, run by the Vermont Ethics Network, participants were asked to pretend they were policy makers in a Vermont Health Plan that guarantees basic coverage to everyone in the state. It is the annual meeting, and they must choose one of four new technologies to add to the plan, for the state can afford to pay for only one: improved arthritis treatment, an intensive monitored exercise program for heart attack patients, an experimental system for helping premature newborns breathe or expanded mammography services. The technologies are equally expensive, but they help different numbers of people in different age groups.

The idea of making such life-and-death choices made many of the participants squirm in their folding chairs.

4 Choices, No Consensus

"I don't like this; this is giving me a stomachache," said Betty Smith, after voting for the newborn resuscitation because, she said, it would save the lives of society's newest members.

In the end, only 8 of the 15 participants were willing to choose, and each option ended up with two votes.

"The budget exercise is a gimmick to help people understand the need to set priorities and to tease out their values," said Jean Mallary, a network coordinator. "It makes people uncomfortable, and that's good. We need to be uncomfortable about these issues."

The ethics network, which has sponsored discussions throughout Vermont and is financed by a $35,000 grant from the Prudential Foundation, will hold a statewide conference next fall to discuss values gleaned from the exercise.

But the efforts are not limited to deciding what kind of care to provide. Some groups have focused on what kinds of care people can refuse to accept.

Two years ago, for example, 30,000 Coloradans participated in discussions run by a group called Colorado Speaks Out on Health. The group's report was influential in revising a state law that allows people to refuse food and water food at the end of life, said Fred Abrams, its director.

Arizona Health Decisions, another state umbrella group, is establishing the nation's first community-based ethics committee, in Yavapai County, said Karen O'Neil, a nurse involved in the program.

California Health Decisions is teaching people about durable power of attorney, which allows people to determine the amount of medical intervention they want at the end of life.

The group is "a tremendous resource of information for us in making public policy," said Harriet Wieder, an Orange County Supervisor. "They give me data to justify policy decisions we make."

'Did I Have a Choice?'

The New Jersey Citizens' Committee on Biomedical Ethics is focused on a person's right to refuse extraordinary medical measures at the end of life.

"My interest in this topic stems from an event in my life when I was 17," said Mary Strong, now 66, a founder of the group. "Three of my friends got polio. One died, one was crippled and one was put in an iron lung. Most troubling to me was, If I got polio and was put in an iron lung, did I have a choice? It was the first mechanical technology that could change your way of life. My concern over this issue has grown as technology has grown."

The most successful programs have taken root in rural states with populist traditions, said Mr. Jennings, the Hastings ethicist, and it remains to be seen if the movement can work in large, urban settings. An attempt to reach consensus on community health values failed in Oakland, Calif., he said, when advocates for AIDS patients, poor children, the elderly and other groups were unable to reach a consensus.

Critics of the health decision movement say most participants are white, college-educated, middle-class people who cannot truly put themselves in the position of the poor, aged and mentally ill who do not come to town meetings.

Organizers of health decision projects say they are aware of this problem and are making great efforts to reach such people.

But when the newly formed Ohio Health Decisions held a town meeting in a poor neighborhood of Cleveland last month, 400 people were expected and only 40 turned up, said Thomas Murray, director of the Bioethics Center at Case Western University. The program will have to find better ways to reach poor people, he said.

For Paul Wallace-Brodeur, executive director of the Vermont Health Policy Council, the state agency working with the Vermont Ethics Network, the value of the project is both public education and policy-making.

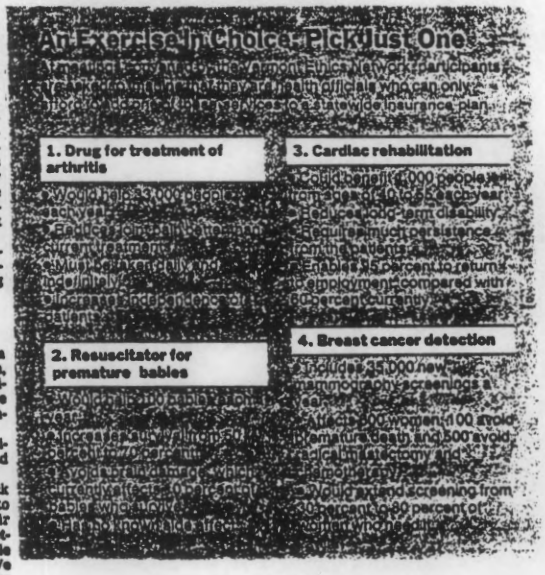
"The underlying thought is that it's hard to set policy in a vacuum," he said.

William E. Sauro/The New York Times

Mary Strong, a founder of New Jersey Citizens' Committee on Biomedical Ethics, which focuses on heroic medical measures at the end of life.

Paul G. Beinert for The New York Times

At meeting in Bristol, Vt., participants played roles of health policy makers; the Rev. Edward Mahoney and Ellen Dorsch led meeting.



Health Care Decisions

Information on organizations involved in the health decisions movement may be obtained from American Health Decisions, 350 Fifth Avenue, New York, N.Y. 10017-6765.

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Supplemental Information in Support of Statement July 18, 1990

The situation we are experiencing in New Jersey concerning health care systems, issues and insurances is complex. Everything we citizens and business people are experiencing is being duplicated across the nation. But because of the differences in the areas of our country, it seems that one or two programs are not necessarily the answer. We in New Jersey therefore should investigate those programs which have been developed and implemented in other states; we should listen to and analyze those proposals that other states are developing; we should truly analyze our situation, divorce ourselves from self-centered opinions and work to develop programs for the citizens.

My statement to the Commission today pointed out that we of the State Chamber of Commerce are basically opposed to mandated health insurance programs. We believe that this is an erroneous course to travel for the injury will be economic devastation of the small business community, inflationary cost increases for products and services to be consumed by New Jerseyans and others and a lessening of quality of health care through the health care system.

Our recommendations made as strongly as a group such as ours can are:

1. to permit the insurance industry to develop and provide no-frills health insurance which will have a reasonable and affordable premium.

2. to encourage the Legislature to develop positive incentive programs for employers who provide insurance packages for employees.

3. to support the Uncompensated Care Trust Fund financing through General Revenues. If this is a societal problem, then society should share in the financial support and not just the business community.

4. The Legislature hold in abeyance any additional bills concerning mandated benefits placed on insurance programs until such time as the current health care issues are studied and positive programs developed and of course implemented.

The New Jersey Legislature has an opportunity to develop positive answers to a complex situation through energetic investigation, reasonable analysis and intelligent solutions.

We are offering the attached information from other states to assist in the commencement of study and the ultimate development of viable solutions.

As we stated in the prepared statement, the New Jersey State Chamber of Commerce will gladly assist th Legislature and Administration in developing solutions.

Donald L. McCambridge
Director, Human Resources Services

SUMMARY
BLUE RIBBON COMMISSION RECOMMENDATIONS

The Blue Ribbon Commission on State Health Insurance recommended the following programs to respond to the problem of the uncovered in Connecticut.

1. Small group reforms and reinsurance mechanism--The Commission adopted, almost in its entirety, the proposal advanced by the IAC. In a close vote, the Commission decided not to recommend a premium tax offset to help cover losses of the reinsurance pool. The insurance industry will continue to lobby for the premium tax offset.

2. Creation of a limited "Blue Ribbon" policy for small employers not currently providing coverage-- Small employers not currently providing coverage would be able to purchase stripped down coverage. We reached a compromise with Insurance Commissioner Kelly which allows the state to sell these policies, through the HRA, to employers with a less than 10 employees in which a majority of the employees are low income (these employees would receive some subsidies). The private market would sell the policy to all other small employers. Negotiations are ongoing about the content of the stripped down policy. We are actively lobbying for a policy free of most of the state's mandated benefits in order to achieve the greatest cost savings.

3. Expansion of Medicaid--Expand Medicaid to the maximum allowed under federal law.

4. Creation of a Medicaid buy-out-- Permit Medicaid to pay a Medicaid-eligible employee's share of employer sponsored coverage, when it is available. The buy-out would apply only in cases where the cost of the premium is less than the state share of the cost of providing Medicaid coverage.

5. Creation of a non-group subsidized product for lower income pregnant women and children-- Pregnant women (up to 250% of poverty) and children (up to 200% of poverty) would be made available a subsidized non-group policy. The premium would be on a sliding scale based on income. Insurers would bid on the program either as an insurer (for the children's program) or as an administrator (for the pregnant women program).

6. Expansion of community health clinics for the low income-- The state would help fund local providers who offer care on a sliding scale to low income individuals. The program would designate a network of preferred providers capable of managing a patient's care with an emphasis on prevention and early treatment of conditions.

Summary of Senate Bill 342

An Act Concerning the Recommendation of the Blue Ribbon Commission on State Health Insurance

I. Provisions relating to insurers' role in improving coverage for the uninsured.

(A) Provides for the creation of a more affordable insurance policy for small employers (no more than 25 full time employees) who have not insured their employees for at least two years. The "special health care plan" could be purchased for up to three years, and would include coverage for all mandated benefits. Low-income employees will be exempt from balance billing by providers. A similar product will be created for purchase by individuals.

(B) Underwriting restrictions applicable to all health insurance covering small employers, including special health care plans:

(1) Requires that time insured under a previous group plan be taken into account in applying an exclusion from coverage under the plan of the new employer for a pre-existing condition.

(2) Requires that such plans be renewable at the option of the policyholder, unless, for example, the policyholder fails to pay premiums or fails to comply with the requirements of the plan.

(3) Prohibits the exclusion of any eligible employee or dependent from the group based solely on the condition of their health.

(C) Rating restrictions on both an annual and an overall basis are placed on policies covering small employers.

(D) All small employers would be guaranteed the right to purchase a group plan of benefits without regard to the health condition of their employees or dependents.

(E) Provisions relating to reinsurance for high-risk individuals within the small group market.

1. Establishes the Connecticut Small Employer Health Reinsurance Pool and requires participation by all carriers.

2. Provides that, subject to certain limitations, any carrier may reinsure with the pool coverage of any eligible employee of a small employer, or any dependent of such employee.

3. Specifies that when coverage is reinsured with the pool, the premium charged the employer can be no more than the reinsurance charge established by the pool.

4. Provides that pool losses will be assessed to participating carriers, first on the basis of their premiums from policies covering small employers; if additional assessments are required after 5% of small employer premiums are collected, such assessments will be made on the basis of the carriers' total health insurance premiums (other than small employer premiums).

II. Medicaid Provisions

(A) Expands Medicaid coverage to include certain children from families with incomes below 100% of the federal poverty level.

(B) Authorizes the Commissioner of Income Maintenance to pay the employee's share of health insurance premium under a group policy for employees who would otherwise be eligible for medical assistance, and to pay premiums for COBRA continuation coverage for chronically ill and disabled persons who are no longer employed and would otherwise be eligible for medical assistance.

(C) Authorizes the Commissioner of Health Services to contract with an insurer to provide coverage for pregnant women who are not eligible for medical assistance and who have incomes under 250% of the federal poverty level.

(D) Authorizes the Commissioner of Health Services to establish grants to health care providers to serve the uninsured based on a sliding scale fee.

(E) Allows for the expansion of the availability of the "Katie Beckett" waiver for disabled children to the federal maximum.

(F) Requires the Commissioner on Hospitals and Health Care to develop a plan to lower the cost shift from Medicare to other payors and to improve its hospital data in specific areas. A report to the Public Health Committee is required by March 1, 1991.

III. Establishes a Health Care Access Commission to study experience under programs established under this Act, and to periodically report to the General Assembly on its findings.

IV. Requires the Insurance and Public Health Committees to study the effectiveness of the bill's provisions relating to the "Blue Ribbon Policy" and the small group insurance reforms. This study is to commence on or after July 1, 1993 and result in a report to the General Assembly by February 1, 1994.

5/3/90

Attachment A

HEALTH CARE for the UNINSURED PROGRAM UPDATE

NUMBER 9 JANUARY 1990

Denver's Scope and Utah Community Health Plan Illustrate Innovative Private Sector Initiatives

Two more Health Care for the Uninsured Program projects — SCOPE (Shared Cost Option for Private Employers) in Denver and the Utah Community Health Plan in the Salt Lake area — have begun enrollment, bringing to nine the total number of demonstration projects entering the enrollment phase.

The two projects have several features in common that set them apart from the other demonstrations supported by The Robert Wood Johnson Foundation. Their experiences will provide answers to some broad policy questions about the most effective ways to increase coverage for the working uninsured population.

First, unlike the majority of the demonstrations, neither project is sponsored or funded by state government. SCOPE was developed by local government, with the support of several private organizations, and the Utah project is strictly a private initiative.

Second, both Colorado and Utah, like most western states, are politically and fiscally conservative, with a strong tradition of individualism and volunteerism. Their legislatures are generally averse to government regulation and reluctant to increase tax revenues for social service programs. Although some of the RWJF projects depend on state subsidies to reduce the cost of insurance, the designers of the Denver and Utah projects never sought state funds; they recognized from the start that they would have to find alternative ways to make their insurance products affordable to their target markets — uninsured small business employees and their families. If these projects are successful, they will help to demonstrate that affordable benefit packages can be developed without state subsidies.

Some of the basic strategies the two projects are employing to enhance affordability are similar to those used in other projects.[1] For example, both SCOPE and the Utah Community Health Plan were able to lower the cost of coverage by negotiating discounts from providers, especially hospitals, and by relying on public facilities to provide some services. In addition, both use managed care arrangements and a limited choice of providers.

But one approach they have adopted is unique — major cost sharing. Many of the plans being developed elsewhere tend to limit copayments and deductibles with the hope of encouraging employer and employee participation. In contrast, the Denver and Utah plans charge substantial copayments or coinsurance for inpatient care (and, in the case of SCOPE, high deductibles for hospital admissions and prescriptions) with the hope of encouraging enrollees to receive preventive and primary care services before they need costly hospital or specialty care. Their success in enrolling members will show the extent to which employees are willing to share in the cost of inpatient care in exchange for access to basic primary

Continued on page 2

H.C.U.P. Progress Report

Project	Enrollment and Firm Size Data			
	Date Enrollment Began	Enrollment Figures 11/30/89	Average Firm Size[1]	Average Group Size[2]
Health Care Group of Arizona	01/01/88	881 lives 209 firms	13.0 (est.)	4.2
Michigan Health Care Access Project: One-Third Share Plan	05/01/88	808 lives 151 firms	5.0	6.5
Maine Managed Care Insurance Demonstration (MaineCare)	12/01/88	629 lives 186 firms	1.6[3]	3.4
Washington Basic Health Plan[4]	01/03/89	7345 lives	n/a	n/a
Wisconsin Small Employer Health Insurance Maximization Project	02/21/89	19 lives 7 firms[5]	2.0 (est.)	2.7 (est.)
Tennessee Primary Care Association (MedTrust)	03/20/89	448 lives 119 firms	1.9	3.8
Florida Small Business Health Access Corporation (FSBHAC)	05/19/89	1124 lives 231 firms	2.8	4.9
Denver Department of Health and Hospitals (SCOPE)	08/22/89	977 lives 98 firms	4.0	10.0
Utah Community Health Plan	09/12/89	341 lives 63 firms	3.1	5.4

[1] Firm size data include all employees in a firm, whether or not they are enrolled in the project's insurance program.

[2] Group size data include enrolled employees and their dependents.

[3] Firm size data available only for enrolled employees, excludes those not enrolled in the MaineCare plan.

[4] With grant funding under the Health Care for the Uninsured Program, Health Systems Resources organized managed care networks that are utilized by the Washington Basic Health Plan. However, the BHP receives no direct funding from The Robert Wood Johnson Foundation. Data regarding firm and group sizes are not applicable, because the BHP insures individuals and families directly, not through employment-based groups.

[5] An additional 32 firms are in the enrollment process, but not all are expected to purchase insurance. Of the 19 lives enrolled, 11 low-income employees receive a premium subsidy.

The Health Care for the Uninsured Program is a national demonstration program of the Robert Wood Johnson Foundation. Technical assistance and direction for the Program are provided by the Alpha Center.

60X

Denver's SCOPE Program

The Shared Cost Option for Private Employers (SCOPE) program is a low-cost, comprehensive indemnity insurance plan for small businesses in the Denver area. Sponsored by the Denver Department of Health and Hospitals and underwritten by New York-based United States Life Insurance Company, SCOPE was developed with grant funds from The Robert Wood Johnson Foundation and local philanthropic groups, including the Colorado Trust, the Piton Foundation and the Hill Foundation. State and local health care organizations and business coalitions also collaborated on the project.

SCOPE began marketing its plan to small employers August 22, 1989, and in the next six weeks received over 8,000 inquiries from interested businesses. By December, 977 workers and their dependents — representing 98 firms — had enrolled in the program. The underwriting staff has been approving applications at the rate of 10 to 12 firms per week. The response to SCOPE has been "truly extraordinary," said David Dunn, senior vice president of United States Life's group insurance operations.

The major reason for the unprecedented response to SCOPE appears to be the low cost of its premiums. Surveys of small businesses in the Denver area showed that the high cost of coverage is the principal factor in an employer's decision not to offer insurance to its employees. Other policies available to small firms cost at least twice the rates charged by SCOPE.

Lacking a subsidy from the state, the project planners were able to lower the cost of insurance mainly by negotiating substantial discounts from participating providers and by requiring high copayments and deductibles for inpatient care. The resulting product, said Project Director Judy Glazner, is a unique cross between a health maintenance organization (HMO) plan, with its emphasis on preventive and primary care services, and a catastrophic plan that covers only large medical claims. SCOPE pays 100 percent of the costs of preventive services, such as well-child checkups and mammography screening, and charges a $15 copayment for visits to physicians for other than preventive care. On the other hand, for hospital inpatient care the enrollee must pay a $250 deductible and 50 percent coinsurance on the first $5,000 in charges. But out-of-pocket expenses above $2,750 per person per year are covered in full.

S.C.O.P.E.
Shared Cost Option for Private Employers

The rationale behind SCOPE's cost-sharing requirements, explained Glazner, is that most people, even those without insurance, do receive hospital care when they need it, particularly in emergencies. The real problem for the uninsured population is in getting physician care, she said. By covering preventive services in full and physicians' office visits for a small copayment, SCOPE should "virtually eliminate access problems" for its enrollees, she said. Furthermore, Colorado's medically indigent program will pay all or part of the coinsurance and deductibles for low-income enrollees who use the participating publicly-supported hospitals.

SCOPE's benefit provisions are also intended to encourage members to seek care early instead of waiting until a condition becomes urgent and requires expensive inpatient treatment, Glazner added. Further, certain preventive and wellness services, especially well-child care, have been shown to be cost-effective, she said.

Survey of Small Employers

In designing the SCOPE plan, project staff took into account findings from surveys of small businesses in the Denver area. According to state employment data, there are about 43,600 employers with 20 or fewer employees in the five-county metropolitan area; 86 percent of these small employers have 10 or fewer workers, and almost 40 percent have five or fewer. A survey of 1,400 small businesses showed that almost 60 percent of the surveyed employers do offer insurance, but the proportion of insuring businesses drops as the size of the firm decreases. Coverage is most limited in the retail trade and construction industries.

Private Sector Initiatives

Continued from page 1

care for themselves and their families.

While Denver's SCOPE program and the Utah Community Health Plan share certain characteristics, they also differ from each other in many ways. This issue of *Program Update* describes each of these projects in detail, including its overall objectives and strategy, service delivery arrangements, eligibility requirements, medical underwriting policies, benefit structure, cost-sharing provisions, premium schedules, marketing program, and enrollment data. ▪

[1]For a further discussion of basic strategies used by projects under the Health Care for the Uninsured Program see *Program Update*, No. 8, October 1989.

PROGRAM UPDATE

This publication is prepared by the Alpha Center under a grant from The Robert Wood Johnson Foundation to provide periodic reports on this national demonstration program.

As a nonprofit health policy and planning center, Alpha specializes in the dissemination of health research and demonstration findings to national, state and local policymakers.

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61X

Based on the survey, project staff estimates that 90,000 adults in the Denver area work full-time for firms without health insurance. With the addition of these workers' families, the target population is close to 250,000 people. Projected enrollment in the first year is 2,500 members.

An important finding from the SCOPE survey is that the characteristics of the target population do not seem to present the adverse risk usually associated with small businesses. About half of the small employer workforce is young — between the ages of 20 and 34 — and only 41 percent is female.

Many insurers rate older workers and female workers as more expensive. In addition, the survey found that contrary to many insurance companies' beliefs, personnel turnover is not a significant problem for small businesses: about 40 percent of the surveyed firms reported no turnover during the previous year.

United States Life Insurance Company's Involvement

After developing the basic framework for SCOPE and defining the target population, the project's next tasks were to find an insurance company to underwrite the plan and then to sell the plan to small employers. The SCOPE staff contacted 40 insurers that market benefit plans in Colorado, but only eight expressed interest in talking to the staff to learn more about the project and, after these initial discussions, only four were willing to bid, Glazner said. Despite the survey findings, most of them still held to their conviction that uninsured small employers are "too risky," she said. Even though employment trend data show that the biggest growth is in the small business sector, these companies were not willing to pursue this market.

United States Life, however, was more than willing to underwrite SCOPE. The oldest stock life insurance company in the country, United States Life is one of the few large commercial carriers that market insurance products to small businesses. According to David Dunn, United States Life already had a firm provider base in Colorado, having set up a preferred provider organization (PPO) in 1985 with 2,000 physicians under contract and an extensive utilization review (UR) program. "We invested a lot of money to develop the PPO and UR programs," he said, "but unless we could expand our market share, we wouldn't recover our investment." SCOPE has given the company an opportunity to increase its market share in a state where competition among insurers is very intense.

Another reason for United States Life's interest in SCOPE, Dunn said, is that the company wanted to experiment with the EPO (exclusive provider organization) model, which generates savings and thus low premiums by requiring enrollees to use only participating providers. In contrast, in a PPO, non-preferred providers may be used but enrollees get more benefits, with lower out-of-pocket costs, if they use providers in the plan. By restricting provider choice, SCOPE can offer more affordable premiums as well as more comprehensive benefits than an indemnity product. SCOPE's benefit package, with its focus on primary and preventive care, especially for children, "makes the most sense for SCOPE's target population," Dunn explained.

Service Delivery Network

Included in SCOPE's service delivery network in the Denver area are 12 hospitals, including two public hospitals, and their medical staffs, and over 1,600 private physicians affiliated with United States Life's PPO. Enrollees may use only these participating providers, except in the case of emergencies.

In the second phase of the project, United States Life has contracted with providers in the Grand Junction area, and SCOPE is now being marketed there. The third phase, encompassing the Front Range area (Colorado Springs, Pueblo, Denver, Greeley and Fort Collins), will be implemented in a few months, Glazner said, and then SCOPE coverage will be available in all the state's major population centers.

Eligibility Requirements

SCOPE is available only to businesses with 50 or fewer employees, including self-employed individuals. Other RWJF projects tend to limit participation to smaller firms. It is, however, the smaller employer that so far has shown the most interest in SCOPE — most of the inquiries have come from firms having 10 or fewer workers while the average number of employees in the firms that have already enrolled is close to four, according to William Lindsay, president, Benefit Management and Design, Inc., an insurance consulting firm that helped design SCOPE and is coordinating the marketing of the product.

At least 75 percent of a firm's eligible employees and their dependents must enroll in SCOPE. But if an employer pays the entire employee premium, 100 percent participation is required.

Unlike other Foundation projects, eligibility for SCOPE is not affected by an employer's past insurance experience. The other programs typically exclude firms that had group coverage during the last year. In particular, projects offering subsidies do not want to attract firms already purchasing unsubsidized coverage. Although the target market for SCOPE is small businesses without employee health benefits, the plan is open also to otherwise eligible small companies that do provide insurance but would like to switch to a less expensive, more comprehensive benefit package. In fact, about 40 percent of the employers calling for information on SCOPE's rates already offer insurance, Glazner said.

The project designers did not intend to encourage such switching, explained Lindsay, but they also wanted to offer affordable coverage for the increasing number of companies that have had to drop insurance because they cannot afford the premiums. "It is a bad policy," he said, "to make groups go without insurance before they can enroll." The project, however, will monitor the ratio of insuring firms to uninsuring firms enrolling in SCOPE. Currently about 43 percent of enrolled companies have recently offered insurance but dropped their coverage. If the percentage goes to 75 percent or more, "we'll know we missed our target market," Lindsay said.

In addition, some employers may be ineligible due to the nature of their business. United States Life, like many commercial carriers, excludes certain types of high-risk

industries from coverage because of their higher medical claims experience. The list of ineligible industries includes, for example, barber/beauty shops, exterminators/crop dusters, mining/quarrying, police, professional athletes, and the taxi industry.

Coverage under SCOPE is limited to full-time employees (who work 30 hours or more per week) and their dependents. No age restrictions apply, as in some other plans, but benefits are limited to $50,000 for enrolled persons age 70 or over (benefits are unlimited for persons under age 70).

Eligibility for coverage is also based on United States Life's evaluation of an individual's medical risk. Applicants in groups with fewer than 10 employees have to fill out a health questionnaire. Anyone found to have certain serious conditions, such as terminal cancer or lung disease, will be rejected from the group plan. Colorado has no high-risk pool for uninsurables, so applicants rejected from SCOPE because of a pre-existing condition will remain without coverage. (Legislation has been proposed, however, to establish a high-risk pool, financed by an employee head tax paid by all employers.) In the case of other pre-existing conditions, an enrollee will be covered for treatment of that condition only after a three-month waiting period (see the section on benefits below).

Benefits & Cost-Sharing Requirements

SCOPE's benefit package is unique because, unlike other indemnity plans, it covers a wide array of preventive and primary care services with no deductibles or coinsurance (a small copayment is required for some services), and yet it also covers catastrophic medical expenses; it requires major cost-sharing for hospital inpatient care and non-primary care outpatient services.

For preventive services, such as routine physical examinations, immunizations, and well-child care, SCOPE pays 100 percent of charges. For each visit to a physician's office for treatment of an illness or prenatal care, the patient pays $15 out-of-pocket. But for hospital admissions, the patient must pay a $250 deductible per calendar year (limited to two deductibles per family), plus half of the remaining covered charges, up to $5,000. While hospital maternity services are subject to the 50 percent coinsurance rate and the $250 deductible, routine nursery care for the baby is free.

In addition, cost sharing is required for certain outpatient services. Outpatient prescription drug coverage, for example, includes both a $50 deductible and 50 percent coinsurance on the first $5,000 in charges. The same coinsurance rate applies to preadmission testing, physical therapy, diagnostic x-ray and outpatient surgery.

Alcohol and drug abuse treatment and psychiatric care are covered but only if provided by participating institutions and, in the case of inpatient treatment, only if preauthorized by United States Life's utilization review organization. The plan will pay up to $500 (50 percent of the first $1,000 in charges) for outpatient alcoholism and drug addiction services per calender year; 45 days per calender year of inpatient care is covered, after the enrollee pays the $250 deductible and 50 percent coinsurance. SCOPE will pay up to $1,000 per calender year for outpatient mental health services, with 50 percent coinsurance. For inpatient mental health services there is a $25,000 lifetime maximum benefit, subject to the $250 deductible per calender year plus 50 percent coinsurance on the first $5,000 in charges.

Supplemental accident insurance covers the first $500, with 50 percent coinsurance on the remaining charges under $5,000, and pays up to $100 for ambulance service. The same coinsurance rate applies to home health care, limited to 100 visits per year, and to convalescent care, limited to 50 days for all confinements for related causes. Other benefits include hospice care, private duty nursing, oxygen, durable medical equipment, podiatry, and survivors' benefits.

SCOPE's pre-existing condition limitations are less stringent than those of most insurance plans. SCOPE has a "3-3-6" pre-existing condition rule for employees and a "3-3-12" rule for dependents. This means that for any injury or sickness for which a person received treatment within three months before he/she became insured under the plan, no charges will be considered covered charges until he/she has not received treatment for three continuous months while insured, or has stayed insured for six continuous months. For dependents, the waiting period is extended to twelve months. In most other insurance plans, these time periods are generally longer and therefore more restrictive.

With the exceptions of mental health and substance abuse services, hospice care, convalescent care, and services for persons age 70 or over, the benefits for each enrollee are unlimited; the plan caps a participant's share of the covered costs at $2,750 per person per calender year. In addition, The SCOPE staff is working on a proposal to establish a credit program for enrollees so they can pay off their coinsurance obligations in monthly installments.

Despite the cap on out-of-pocket expenditures, the deductibles and coinsurance required for hospital services could be financially devastating to low-income enrollees. SCOPE therefore devised a plan to cover part or all of the coinsurance obligations of those with incomes at 150 percent of the poverty line and below, with the amount of the subsidy based on an enrollee's family income. To be eligible for a subsidy, an enrollee has to use the two publicly supported hospitals — University Hospital or Denver General Hospital. Each hospital will deduct some or all of the coinsurance depending on the patient's income level from its annual appropriation provided by the legislature under the state's medically indigent program.

Premium Rates

The premiums for SCOPE are far lower than premiums for other comprehensive benefit plans available in the Denver area. They are based on the age and sex of the employee, on the geographic area, and on whether individual or family coverage is chosen. The monthly single rate for a 35-year-old male employee in Denver, for example, is about $49, and for a 35-year-old female worker, about $67. The family rate applies to a couple — an employee and spouse — as well as to a family with one or more children. A single female employee aged 25, with two children, would pay about $118 per month; the rate would be the same if coverage included a 25-year old woman and her husband, or both parents and any num-

63x

ber of children (see the chart below showing approximate monthly premium rates by age, sex and marital status tier for employees in Denver).

Employers are required to pay at least 25 percent of each employee's premiums, although surveys of small firms in the Denver area indicated that many would be willing to contribute half or more. Surveys also showed that among the employers that do offer insurance, almost 75 percent pay the entire premium for full-time employees.

Shared Cost Option for Private Employers (SCOPE)

Monthly Premium Rates* by Age, Sex and Marital Status Tier, in Denver
Effective September 1, 1989

Age	Single Male	Single Female	Family
<30	$ 35.45	$ 66.50	$118.10
30-34	$ 40.99	$ 63.85	$129.39
35-39	$ 48.58	$ 66.92	$138.88
40-44	$ 58.27	$ 77.40	$145.37
45-49	$ 70.06	$ 91.88	$155.86
50-54	$ 84.79	$111.18	$171.08
55-59	$103.25	$136.64	$200.38
60-64	$127.37	$168.70	$241.78

* Rates are shown for groups of fewer than 10 employees, which comprise the majority of SCOPE enrollees.

SOURCE: Shared Cost Option for Small Employers, Denver, Colorado

Marketing

The SCOPE plan was officially unveiled at an August 22 news conference, attended by the governor and many of the city's business leaders. Since then the project has been marketing the plan directly through television, radio and print advertising and direct mail promotion. It is selling the program through agents and brokers. Benefit Management and Design, an insurance consulting firm, is coordinating SCOPE's broker marketing program. Inquiries from small employers are referred to independent insurance brokers, who then contact the businesses in an effort to sell them a SCOPE policy. The project is also monitoring the performance of the brokers to make sure that they respond quickly and accurately to all leads they are given and that they are not unfairly representing the SCOPE plan. Already several brokers have been dismissed from the SCOPE broker network, according to Benefit Management and Design's Lindsay.

Reaction to SCOPE's Marketing

The response to SCOPE's marketing campaign has been overwhelming. Additional telephone lines have been installed and extra personnel hired to handle the inquiries from interested firms. United States Life has had to increase its underwriting staff to review applications from individual companies and their employees. According to SCOPE's marketing consultant Lindsay, the number of applicants is about twice what project planners expected.

United States Life's Dunn was initially surprised at the favorable reaction to SCOPE's promotion. "We were afraid that the product wouldn't sell because it is so complicated," he said. However, people are attracted by the low premiums and seem to be willing to give up full coverage of smaller, more frequent medical claims in return for protection from less frequent, catastrophic claims, he explained.

But potential enrollees are not the only ones that have expressed a keen interest in SCOPE. A number of insurance companies in Colorado and elsewhere have contacted SCOPE headquarters to get more information on the program. While some local firms may have a "sour-grapes attitude" that they were not selected to underwrite SCOPE (even though only a handful of insurers showed any interest before), most have been supportive, Lindsay said. The responsible companies recognize, he explained, that any program that alleviates the uninsured problem benefits the entire health care system, including insurers, by lowering hospitals' uncompensated care costs and thus reducing cost shifting.

According to SCOPE staff, several insurance firms, encouraged by SCOPE's success, are considering developing their own low-cost preventive/primary care benefit products. But the project's sponsors welcome the competition. "More competition for SCOPE means that more people will be covered," said project director Glazner.

SCOPE may also revise the way insurance companies market new products. Most "do a terrible job of marketing," Lindsay said. But effective marketing of SCOPE, through radio, television and print advertising and direct mail promotion, is changing public opinion about health insurance, he said, and forcing employers to respond.

In addition, the statewide and even national attention that SCOPE is attracting has raised legislators' sensitivity to the plight of the uninsured. After four unsuccessful attempts to effect establishment of a state high-risk pool, supporters of the bill believe that chances for passage in the next legislative session are much improved, thanks to SCOPE. •

64X

Utah Community Health Plan

The Utah Community Health Plan (UCHP) is a comprehensive health insurance program HMO available to uninsured small businesses in the Salt Lake area. Intermountain Health Care (IHC), a private, nonprofit health care provider system in Salt Lake City, developed the plan with funds from The Robert Wood Johnson Foundation. Using a tightly-controlled network of community health clinics for primary care and specialty physicians and hospitals for secondary care, UCHP offers an affordable benefit package for uninsured workers and their families. It costs about 40 percent less than comparable plans in the area.

IHC's new health maintenance organization product for uninsured small businesses is part of a broader strategy aimed at the state's entire medically underserved population. The Health Care Access Steering Committee, a coalition of Utah community and health care leaders, including IHC Vice President for Research and Development David Burton, has been working for several years on proposed solutions to the state's uninsured problem. In view of the legislature's conservative nature, the committee knew that any initiative to alleviate the problem would have to be privately-funded. The Utah Community Health Plan, an entirely private initiative, is the first step in the group's long-range master plan. Its board of directors includes not only IHC, but also Holy Cross Hospital, University Hospital and the Salt Lake Community Health Centers, making UCHP a collaborative effort of key health care providers.

According to Burton, the plan was first to establish a private, nonprofit network of primary care clinics for the medically indigent in the Salt Lake area and then link it to a secondary care system by negotiating discounts with specialists and hospitals. The initial target would be individuals employed by Salt Lake County small businesses that don't offer group coverage. This is the approach being followed by UCHP. If UCHP demonstrates that a privately-funded system of managed care can control utilization and keep the program within its budget, he said, then "we can go to the legislature and ask for public funds to expand the program" to other segments of the uninsured population. "Private initiatives alone cannot solve the problem," Burton said.

The immediate focus of the coalition's lobbying efforts is a bill to establish a state comprehensive health insurance pool, which would provide benefits to individuals excluded from group insurance plans (including UCHP) due to serious health problems. In the past few years the legislature has rejected proposals for a state high-risk pool, mainly because they called for new appropriations to fund the pool. Chances of legislation passing in the 1990 session are better, according to Michael Stapley, chairman of the Health Care Access Steering Committee. One reason for the improved outlook, he explained, is that the bill has broader support, especially from hospitals concerned about increasing uncompensated care costs. In addition, the revised bill would finance the pool from general revenues, which are now at a surplus after several years of deficits.

Survey of Small Employers

UCHP's basic design was developed from market research conducted by IHC with grant funds from The Robert Wood Johnson Foundation. Surveys of the small business market in Salt Lake County showed that about 63,000 persons are employed by companies without insurance benefits and that over 40 percent of businesses with 10 or fewer workers don't offer coverage. The high cost of premiums was the major reason these small businesses don't provide insurance.

Based on the preferences stated by small employers in the surveys, IHC determined that product design should focus on reducing the cost of coverage rather than enhancing service benefits and should minimize or eliminate deductibles. The project estimated that over 66 percent of the target small employer market — or about 16,000 firms — would be interested in enrolling in a low-cost plan that would provide primary health care through a network of community health centers.

Service Delivery Network

UCHP's primary care network, currently operating only in Salt Lake County, includes five medically needy clinics in low-income areas (two supported by IHC) that are managed by Salt Lake Community Health Centers, as well as two primary care physicians. Enrollees choose a primary care physician at one of these seven sites to provide basic preventive and primary care services or to refer them to participating specialists and hospitals. Six Salt Lake City hospitals provide inpatient services to enrollees: Holy Cross Hospital, University Hospital, LDS Hospital, Primary Children's Medical Center, Alta View Hospital, and Cottonwood Hospital Medical Center.

UCHP pays the primary care physicians at the clinics on a monthly capitation basis, adjusted for age and sex. Specialty physicians participating in the plan are paid on a fee-for-service basis, but at a 35 percent discount. The six hospitals are paid on a per diem basis, also at substantial discounts. The plan was also able to negotiate a reinsurance arrangement with the hospitals. For the first 27 days of a hospital stay, UCHP pays the per diem rate; the hospitals provide free inpatient care after 28 days.

Eligibility Requirements

Like most of the other Robert Wood Johnson Foundation projects, but unlike SCOPE, the Utah Community Health

65X

Plan is available only to uninsured small businesses. An employer must have 19 or fewer full-time workers and cannot have offered any kind of group health coverage within the previous year. A group must also meet enrollment participation requirements, the minimum percentage of participating employees varying with the size of the firm. While UCHP encourages all dependents to enroll, it requires a minimum participation rate of 75 percent.

Only full-time employees are eligible to join the plan; firms may write their own definitions of full-time employment, but UCHP requires a minimum of 19 hours per week. Employers also decide how long an employee must have worked before coverage can begin. At present, coverage is limited to individuals 64 years of age and younger, as the vast majority of those 65 and older are covered by Medicare.

To protect the plan from catastrophic expenses, UCHP has developed underwriting criteria, however its guidelines are more liberal than those used by other small-business insurers. UCHP does not automatically disqualify firms with high turnover or seasonal employment as many insurers do. It does exclude certain industries from coverage because they are believed to be associated with excessive medical claims. The list of excluded industries includes such businesses as beauty shops, hotels/motels, and mining; certain other types of employers, including medical and dental offices and property management firms — also perceived as high-risk industries — will not be pursued by UCHP but could be considered for enrollment if they contact the plan. UCHP estimates that about 20 percent of the target small businesses are ineligible because of their industry's high risk. The project hopes to relax the industry screen later if enrollment increases to the extent that it can absorb these high-risk groups, said William Willson, UCHP's executive director. Such businesses would probably have to pay additional premiums.

As part of its underwriting policy, UCHP also assesses the medical risk of each employee. Every attempt is made to cover the entire group. However, applicants who don't meet height and weight criteria or have certain serious, pre-existing medical conditions may be denied coverage on an individual basis. In the case of pre-existing pregnancy, a family's coverage will not start until after delivery.

Earlier, the project estimated that 10 to 13 percent of uninsured workers in the target market would be excluded from the plan because of individual medical risk. So far, less than 5 percent of applicants have been denied coverage. In keeping with the project's philosophy that "every attempt will be made to enroll all members of a group," UCHP underwriting staff and medical consultants are working with each individual who has a history of health problems to help him or her qualify for coverage. For example, persons with diabetes, who traditionally are rejected from insurance plans, could become insurable if they agree to change their dietary habits and thus control their disease. "We are going that extra mile" to include, rather than exclude, individuals with medical problems, said John Rettie, UCHP's business manager. Furthermore, when individuals are denied coverage because of medical problems, UCHP sends them a letter referring them to primary care facilities and hospitals willing to treat patients based on their ability to pay.

Benefits & Cost-Sharing Requirements

As a health maintenance organization, UCHP is designed to encourage enrollees to obtain preventive and primary care services before a medical problem necessitates expensive hospitalization. Little or no cost-sharing is required for most outpatient physician services, but copayments increase as the level of care rises. Unlike SCOPE, the Utah plan has no deductibles.

UCHP covers 100 percent of the charges for immunizations; laboratory and x-ray services; physicians' services for minor diagnostic tests, inpatient care, outpatient surgery, and other outpatient services (except mental health services and maternity care); and nonsurgical, nonemergency outpatient facility services. Ambulance services, certain home health and hospice services, and dental services in the case of accidental injury are also covered in full.

Prescription drugs are covered after a $5 copayment. A $10 copayment is required for primary care office visits, including periodic well-baby and routine adult physical examinations, while office visits to specialists require a $20 copayment. For emergency room services and extensive adult physical examinations, enrollees pay $50; for outpatient surgical facility services, the copayment is $75. Physicians' maternity services, including prenatal and postnatal care, require a $100 copayment per delivery.

For hospital inpatient stays, members are charged $150 per day for the first four days, with full coverage thereafter. Enrollees pay $350 per day for the first three days of inpatient maternity care; the plan pays all charges from the fourth day on.

UCHP also covers outpatient and inpatient mental health and substance abuse services, with certain restrictions. During the first year of coverage, enrollees pay 50 percent coinsurance for mental health outpatient visits; after that they pay $20 for each visit, limited to 15 visits per year. Up to four days of hospital care — one stay per year — are covered, with a $150 daily copayment, but inpatient care is limited to acute detoxification and acute crisis services.

Pre-existing conditions are covered in full after a 12-month waiting period. During that waiting period the plan pays 50 percent of charges for covered services relating to a pre-existing condition.

Premium Rates

By using a managed care system, negotiating discounts from participating providers, and requiring substantial cost sharing for inpatient care, UCHP was able to develop a benefit package that costs about 40 percent less than comparable plans in the area. Premium rates are based on age, sex and whether individual or family coverage is purchased. The monthly individual rates range from about $56 for men 30 years of age and younger to about $110 for men 60 to 64 years old; for women in the youngest age group, the rate would be about $73 per month and for those in the oldest group, about $111. Coverage of one child costs about $20 more per month, while for two or more children, the additional cost would be about $47. For example, the monthly premium for a 25-year-old man, his 25-year-old wife, and their two children would be approximately $176 — $56 for the man

plus $73 for the woman plus $47 for the children (see the chart on this page).

UCHP requires employers to contribute at least $50 to each employee's monthly premium payment, although a lower contribution could be negotiated, depending on the employer's financial status. Most of the firms enrolling in the plan have agreed to pay $50 per employee, and many want to pay the entire employee premium, according to the project's Rettie.

Utah Community Health Plan

Monthly Premium Rates by Age and Sex, December 1989

AGE	MALE	FEMALE
<30	$ 56.26	$ 73.35
30-39	$ 59.52	$ 69.69
40-44	$ 59.30	$ 64.06
45-49	$ 62.39	$ 65.35
50-54	$ 74.71	$ 77.67
55-59	$ 95.96	$ 97.60
60-64	$109.74	$111.02

Additional Monthly Premium for Family Coverage

One Child	Two or More Children
$20.41	$46.88

SOURCE: Utah Community Health Plan, Salt Lake City, Utah.

Marketing

The project was able to reduce the cost of its benefit package by another 10 percent by using in-house marketing staff rather than independent insurance brokers to sell the product. Another reason for using in-house personnel, UCHP explained in its sales and underwriting manual, is that they "can more closely monitor risk and have direct access to market trends. In addition, a salaried marketing staff is best suited to accurately communicate the features of its HMO product to potential consumers," the manual said.

To promote the plan, UCHP is relying mainly on direct mail advertising to target employers, public service announcements and contacts with public and private agencies, with limited paid advertisements. UCHP began its sales campaign in September, and as a result, enrolled five firms, with a total of 26 members, effective October 1. An October 25 news conference, at which the mayor endorsed the insurance plan, generated 400 telephone calls from interested firms the following day, UCHP's Willson said. By December 1, a total of 63 businesses had enrolled, including 341 employees and their dependents

Plans for Future Market Expansion

UCHP has projected an enrollment of about 5,000 by the end of its third year of operations. But an estimated 6,000 to 7,000 members are needed to reach the "break-even point," where revenues begin to offset overhead expenses. The current market of 20,000 small businesses may not be large enough to generate the enrollment needed to break even. In addition, Intermountain Health Care has indicated that it will not subsidize the program beyond the $550,000 in start-up funds already committed. Without continued support from IHC, the project's future financial viability may depend on expanding its market. UCHP is already exploring several expansion options.

One proposal under consideration is expanding the program to rural communities in the Salt Lake City area and to other areas in the state. The project is also examining the feasibility of using UCHP's existing delivery system to serve Salt Lake County's Medicaid population through a capitation contract with the state Medicaid office. Another possibility being studied is to offer coverage directly to uninsured individuals, without the involvement of employers.

Expansion of the market base will not only improve UCHP's future financial stability but also will go further in addressing the state's broader medically indigent problem. ■

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Californians Without Health Care Coverage:

A Report and Recommendation

Californians for Health Options Without Mandates

68X

This report was prepared by Californians for Health Options Without Mandates.

Californians for Health Options Without Mandates is a coalition of trade associations, organizations and businesses dedicated to finding a fair and responsible solution to the problem of California's 4.8 million residents without health coverage. The coalition opposes "mandate" legislation forcing employers to provide health coverage because it would severely hurt small businesses, put California at an economic disadvantage, and not adequately address the underlying cause of the problem — the soaring cost of health care. The coalition supports a combination of public and private sector efforts that would make health coverage available to all Californians by addressing the key issues of affordability and accessibility.

4.8 Million Californians Without Health Coverage

In Brief...

The Problem

About three-quarters of the the 4.8 million Californians without health coverage live in low-income households. Two-thirds are children and young adults. Although approximately 75 percent are working people and their dependents, many earn low wages and others are employed in part-time or temporary jobs. Two-thirds of these working people are employed in small firms where narrow profit margins, high employee turnover, and high costs prevent employers from offering group health coverage.

New data released by the Census Bureau demonstrates that the number of people lacking health coverage is lower than had previously been reported, that the number of people with employer-sponsored health coverage has increased, and that 2.7 million of the 4.8 million uncovered lack coverage for the whole year, while 2.1 million obtain coverage at some point during the year.

Mandates: How Not to Address the Problem

Legislation forcing small employers to offer employee health coverage would not work because it does not address the issue of affordability. Such legislation would force many small employers to reduce their employee rosters and hold back on new job creation. For some, the added cost would simply force them out of business.

Private/Public Cooperation: How to Address the Problem

Make private health coverage affordable to small businesses and their workers through tax incentives and guarantees, including:

- Guaranteed availability of health coverage to small employer groups regardless of medical history;
- Guaranteed renewability of an employer's health coverage from year to year, regardless of claims experience;
- Guaranteed continuation of coverage if an employee changes jobs, without the application of a new pre-existing condition limitation;
- Limits on yearly rate increases and cumulative rate increases for health care plans in the small business market;
- Broadened tax credits to small employers offering employee health coverage;
- A reinsurance pool that spreads the losses of high-risk individuals among health coverage carriers industry-wide;
- No-frills coverage that is affordable and available to small businesses and their employees;
- A special plan available to small employers with low-income employees which would be more affordable because it would be exempt from balance billing by providers;
- Cost containment, including reforms in tort law, better data collection on provider services, removing the ban on employment of physicians, and increasing rates paid by Medi-Cal to providers.

In addition, extend Medi-Cal benefits to reach all those living below the federal poverty level. Create a buy-out for those poor and near poor who can obtain employer sponsored coverage, but who need a subsidy to assist them in paying their share of the premium.

70X

Executive Summary

4.8 million Californians do not have health coverage. Californians for Health Options Without Mandates, a coalition of businesses, professional organizations, and citizens, believes this complex social problem can be solved using the resources of the government and the private sector.

The Problem

Based on recently released data from the Census Bureau, it is estimated that since 1985 there has been a modest decline in the number of Californians uncovered. There are now approximately 4.8 million Californians without health insurance, 2.7 million of whom lack coverage for the whole year. Although a diverse group, the overwhelming majority of Californians without health coverage have one thing in common: low household income. Consider:

- 1.4 million live in households whose income is below the federal poverty level (1989: $12,100).

- Seventy-five percent, or 3.6 million people, live in households whose income is less than three times the federal poverty level for a family of four (1989: $36,300).

- Two-thirds, or 3.1 million, are children and young adults.

- 3.7 million of those without health coverage are working people and their dependents.

- Many work part-time or hold seasonal jobs.

- On a national level, more than 90 percent of working people without coverage (18.6 million) earn less than $20,000 a year.

- The majority of working people without coverage are employed at firms with less than 25 employees, where narrow profit margins, high employee turnover and the high cost of health coverage prevent employers from offering coverage.

Employer Mandates: How not to solve the problem.

Requiring all employers to provide health coverage is appealing because it promises a simple solution to a complex social problem. That promise, however, is a false one for many reasons.

First, many small businesses cannot afford health coverage. Skyrocketing medical costs of the past decade have driven premiums beyond the reach of many employers, especially small businesses. In a national survey, 65% of small employers cited affordability as the principal barrier to providing health coverage.

An employer mandate would create severe economic difficulties for those it is supposed to help — workers. Many small California businesses would simply cut back on employees, reducing jobs by the thousands. Among those most severely affected would be the lowest wage workers. This is the primary reason that the Small Business Committee of the U.S. House of Representatives voted *against* employer mandates.

Small businesses would also suffer. More than 50 percent of all small businesses fail within their first two years. Adding an extra burden that increases costs by up to 25 percent would drive many firms out of business and retard one of the most dynamic segments of the California economy. A national survey indicates half of small employers not now offering health coverage would lay off workers, reduce employee hours or cease doing business entirely, if required to purchase health coverage.

71X

A responsible and fair approach to solving the problem of those without coverage is to develop a targeted program involving both the public and private sectors.

A Positive Approach

Because most working people without coverage are employed at small firms, more needs to be done to make health insurance affordable to small employers, including tax incentives and guarantees. Among the initiatives we propose:

1. Eliminate requirements that small employers provide comprehensive health benefits packages. These drive up costs for small employers, many of whom have little choice but to offer no health benefits at all.

2. Instead, small employers should be encouraged through tax breaks to purchase low-cost "no frills" plans that provide coverage at an affordable cost.

3. Also, permit small employers who employ low-income employees as the majority of their workforce to purchase more affordable coverage that is exempt from balance billing by providers.

4. Guarantee the availability of health coverage to small employers by establishing a reinsurance pool that permits all those offering health coverage to pool high-risk individuals and groups, spreading the losses industry-wide.

5. Increase stability in the small group market by enacting fundamental reforms in carrier underwriting and rating practices that would:

- Guarantee availability of health coverage to small groups by requiring all carriers in the small group market to accept small employer groups without regard to the medical history of their employees and dependents.

- Guarantee renewability of coverage for small employers by precluding carriers from discontinuing an employer's coverage, except for non-payment of premium, fraud, or failure to meet participation requirements.

- Guarantee continuity of coverage for employees changing jobs by prohibiting the re-application of pre-existing condition limitations, such as poor health.

- Eliminate dramatic increases in premiums by limiting both yearly premium increases and the rate corridor between the highest and lowest rates of all carriers writing coverage in the small group market.

6. Encourage small employers to purchase employee health coverage by broadening the tax credit allowed by the recently passed SB 1207.

7. Achieve greater cost containment through a variety of measures, including reforms of tort laws, use of data collection regarding provider services, removing the ban on employment of physicians, and increasing the rates paid by Medi-Cal to providers.

The total number of people without health coverage would dramatically decline if low-income children and adults had access to public assistance programs like Medi-Cal. We recommend that public assistance programs such as Medi-Cal be extended to the poor and near poor via the following measures:

1. Expand Medi-Cal so that all persons with an income below the federal poverty level are eligible for Medi-Cal benefits.

2. Allow the near poor (e.g. those with a household income between 100% and 150% of poverty) to purchase primary and preventative coverage from Medi-Cal on a sliding fee basis.

3. Establish a buy-out for lower income working people who have access to coverage through their employers, but who need a government subsidy to help pay the premium.

Characteristics

Characteristics of the Population Without Health Coverage

To date, the California Policy Seminar Report,[1] which examines the number of Californians without coverage using the 1986 Current Population Survey (CPS), has been virtually the only source of information concerning the characteristics of the uncovered in California. A new study recently released by the Census Bureau demonstrates that flaws in the 1986 CPS questionnaire resulted in an overstatement of the number of people without health coverage and a lack of specific information about important characteristics of the uncovered. Before major policy decisions are made regarding the best approach to responding to the uncovered problem, the profile of the California uncovered population should be re-examined in the context of this more current and more accurate information.

The Census Bureau report[2] indicates that the number of those lacking health coverage is lower than previous reports suggest. The flaw in the 1986 CPS was addressed in the March 1988 CPS by making major changes in the way health insurance questions were asked on the CPS. According to the Census Bureau report, the questionnaire modifications resulted in "a dramatic decline in the estimate of the uninsured between March 1987 and March 1988 (from 37.4 to 31.0 million persons)."[3]

Furthermore, the 1986 CPS did not differentiate between the chronically uncovered (those without health coverage for the entire year) and the transiently uncovered (those who have health coverage for part of a year, but lose it temporarily due to the circumstances such as a change in jobs).

The Census Bureau does not contain state specific information. However, based on extrapolations from data provided for the western states, it is possible to derive estimates for the California population.

In California, it is estimated that 2.7 million of the 4.8 million without coverage are chronically uncovered, while the remaining 2.1 lack coverage only temporarily. Such a dichotomy in the uncovered population has a major impact in terms of analyzing the value of the type of solutions needed to address the different concerns of these two groups.

The Census Bureau report also provided other important information, including;

- The number of people with employer sponsored coverage has increased, despite increases in health care costs.
- The 2.1 million transiently uncovered in California obtain coverage, on average, within four months of losing coverage.
- Preliminary analysis of the chronically uncovered suggests that this group tends to have lower income, and therefore does not have the resources to afford health coverage, or is "uninsurable" due to an existing medical condition.

The various reports concerning the uncovered in California and nationally confirm that while the uncovered population is comprised of many diverse groups, the vast majority of them are low income. The problem is thus fundamentally one of poor economic circumstances. Although a significant number of those without coverage either work or live in households with a working

73x

head, most earn low wages and many hold only part-time or seasonal jobs. Also, these low-wage earners are typically employed by small businesses, including many who are self-employed. In addition, a large majority of those without health coverage in California are children and young adults.

The problem is fundamentally one of low income.

In California, 29% of those without coverage (approximately 1.4 million people) have family incomes below the poverty level; 44% have family incomes below 1.5 times the poverty level (approximately 2.1 million people); and 75% have family incomes of less than three times the federal poverty level (approximately 3.6 million people).[4]

The national profile resembles California's. The core group — those without health coverage for a year or more — are lower income, more likely to be unemployed and minority group members, and generally having poorer health than the transiently uninsured.[5] Nationwide, 66% of those without coverage live in families with incomes less than two times the federal poverty level.[6]

Many of those reporting to be without health coverage actually have coverage for part of the year.

In California, 2.1 of the 4.8 million without coverage are transiently uncovered: that is, they are uncovered for only part of the year and do obtain coverage, on average, within four months of losing coverage. Many times, the temporary condition of lacking health coverage is due to a change in jobs. The remaining 2.7 million are uncovered for the entire year.[7]

Two-thirds of those without coverage in California are children and young adults.

Almost one-third (30.9%) are children younger than 18 and almost 90% of these children are in families with incomes less than three times the federal poverty level.[8]

Another third (32.7%) are young adults between the ages of 18-29.[9]

Many people without coverage hold lower income jobs.

Many are at or near poverty and work at or near the minimum wage. Nationally, three-fourths of all workers without coverage earn less than $10,000; nearly all (93%) earn less than $20,000.[10]

Furthermore, these workers tend to be employed in lower-wage industries. For example, two-thirds of employees in the low-wage textile, clothing, and leather manufacturing industries have no coverage, compared to only 9% of employees in durable goods manufacturing.[11]

Simply offering health coverage to low-income employees would not necessarily guarantee significant improvement. For most low-income employees, paying the employee share of the premium, coinsurance and deductibles would be an insurmountable barrier. It is unrealistic to expect a family breadwinner making $10,000 a year to be able to afford the $100 or more per month an employee pays for family coverage, plus a deductible of several hundred dollars and 20% of health care bills not reimbursed by insurance carriers. The amount that these employees have to pay for health coverage is a far greater percentage of their total income than it is for those with the median American family income of $30,850.

The majority of working people without coverage are employed by small businesses.

National surveys demonstrate that approximately two-thirds of this group work for firms with fewer than 25 employees.[12]

Only 46% of businesses with less than 10 employees offer health benefits, compared to over 90% of firms with more than 25 workers.[13]

High health coverage costs, narrow profit margins and high employee turnover are the main prob-

lems faced by small businesses that discourage or prevent them from providing health benefits.[14] However, as small firms grow and can afford to offer employee coverage, surveys show that they are likely to do so.[15]

Many working people without coverage are employed in part-time or seasonal jobs. Small businesses not offering health coverage are generally in industries that employ twice as many part-time workers and also employ the greatest number of younger and seasonal workers.[16] In California, the industries having the greatest percentages of workers without coverage are agriculture, forestry and fishing (42.6%), personal and household services (39.4%) and retail (27.8%).[17]

Approximately half of those without health coverage in California hold some kind of job. However, only 11% of those employed full-time (excluding the self-employed) lack health coverage.

By contrast, approximately 60% of the those working in either part-time or seasonal jobs lack health coverage. Seasonal and part-time workers are less likely than full-time workers to receive health benefits provided by their employers, due to the much greater cost involved.

Approximately 30% of the self-employed lacked health coverage.[18]

Due to rising health care costs, health coverage has become increasingly expensive.

Over the last two decades, national health care spending has increased at an average annual rate of approximately 12%, making health benefit plans more expensive for employers.

The impact of rising health care spending has been exacerbated for the private sector by cost shifting from Medi-Cal and Medicare. On the hospital side alone, it is estimated that the shortfall between expenses and payments by government - funded patient treatment accounts for 15-20% of private charges. Consistent underfunding of the Medi-Cal and Medicare programs causes the vast bulk of the cost shift. The cost shift will not be significantly reduced until and unless the state and federal governments pay their fair share.

75X

Inadequacies

The Inadequacies of an Employer Mandate "Approach"

In searching for solutions to the problem of Californians without health coverage, some look to a mandate that forces employers to provide health coverage for their employees, or to a "play or pay" law that would levy a tax on employers who don't offer coverage . The mandate — in either form — appears to offer a quick fix to this complex problem. Statistics clearly demonstrate, however, that the problem of those without health coverage is primarily one of low-income. An employer mandate does not address the low income problem and ignores the difficulties small businesses (where the bulk of working people without coverage are employed) have in obtaining affordable health coverage.

Furthermore, employer mandate legislation that promises a host of subsidies for small employers and their low-income employees must be viewed skeptically. The State of California has failed to meet its financial obligations with other social services programs. The underfunding of Medi-Cal and the county hospital programs are good examples. The government's role to date has involved a string of broken promises. It is estimated that the Brown/Margolin bill would cost the state between $3 and $7 billion. Is the state, which is already in a deficit situation, prepared to make – and satisfy – this financial commitment?

Even if the necessary ERISA waiver were obtained and employer mandate legislation went into effect, an employer mandate would not solve the problem. What it would do, however, is cause serious problems for many small employers and their employees. Some would be forced out of business. Others would cut back on current employee rolls. New job creation would be retarded. All of this would hurt the very people who are supposed to be helped by a mandate.

An employer mandate fails to address the real needs of the core group without coverage, the poor and near poor. This group is best helped by expanding public assistance and creating more public/private initiatives that target their problems.

The federal government has permitted Medicaid coverage, government's principal health "safety net" for the poor, to decrease dramatically over the past decade to an all-time low. It now covers only 38% of the poor. A full 40% of Americans added to the ranks of those without health coverage in recent years is attributable to the failure of the Medicaid eligibility threshold to keep pace with rising inflation. Consider the following:

- 1.4 million of Californians without coverage (approximately 30% of the total) have incomes below the federal poverty level.
- Three-quarters have a family income of less than three times the federal poverty level.
- One third are children, 90% of whom live in families with an income of less than three times the federal poverty level.
- Working people without coverage tend to be in lower wage jobs.[19]

The proper role of government, and the first priority of a program for those without coverage, must be to provide health care to low-income individuals who are truly needy.

A mandate does not address the principal reason more employers are not offering health coverage: rising health care costs.

Affordability is the principal barrier to the purchase of health coverage, particularly for small businesses. In a 1989 National Federation of Independent Businesses survey, 65% of small

76X

employers not providing coverage cited affordability as the primary obstacle to providing health coverage to their workers.[20] Over 45% said they would purchase coverage if the cost were reduced by 20%.

A mandate will create a host of harmful consequences for small businesses.

Imposition of an employer mandate strains the small business community and jeopardizes job opportunities for many workers, especially low-income workers, the young and the elderly. The considerations listed below were among those that led the U.S. House of Representatives Committee on Small Business to come out *against* mandating employer-provided health coverage.[21]

The very characteristics that have made small businesses such a dynamic economic force also make them especially sensitive to an employer mandate's labor costs.

• Small firms are a source of millions of entry level jobs and jobs for those marginally attached to the work force. These firms also employ a disproportionate share of young, old, female and part-time workers, and have a high turnover — factors which increase their health care coverage costs.[22]

• Small firms have experienced rapid growth in jobs. Businesses with less than 100 employees created two-thirds of the net new jobs over the past decade. Furthermore, Dun & Bradstreet estimated in a 1986 study that firms with less than 50 workers would account for nearly half of the 2.6 million jobs expected to be created in 1987.[23]

• Nationally, more than half of working people without coverage are employed in the retail trade and service industries. Between 1980 and 1985, employment in these industries and in the construction industry grew by approximately 17%, four times the rate in industries with higher incidences of coverage. In 1985 these industries accounted for 35% of total employment, compared to 30% in 1982.[24]

A mandate would cause many small employers to lay off workers or reduce their hours.

With lower profits, less stability, and greater employee turnover, small businesses are least able to afford an employer mandate. Due to the low wages earned by the bulk of workers lacking coverage, requiring employer-sponsored health coverage would entail significant increases in compensation, little of which could be shared with employees through reduced wages—to do so would be illegal. At the point where there is no "give" in the wage and no "give" in the benefit, there is "give" only in one place: the job itself. Trading health coverage for a job is an impossible choice for the population in question, as it should be for policy makers.

A 1989 survey by the National Federation of Independent Businesses found that half of small employers not offering health care coverage would lay off workers, reduce employee hours or cease doing business altogether if required to provide health care coverage.[25]

In a recent New York study, it was estimated that between 34,000 and 91,000 employees would lose their jobs if a mandate were implemented in New York. The primary victims of a mandate would be the low-wage earning, small business employees who could be expected to lose their jobs — wiping out not only their short-lived health coverage, but their income. Because California has a large number of working people without coverage, it is very likely that the number of employees who would lose their jobs would be even higher.[26]

The economic vulnerability of small businesses cannot be ignored.

A majority of businesses that employ the bulk of low income workers are themselves at the low end of the income scale. Two-thirds of all bankruptcies are in the service and trade industries and two-thirds of all these bankruptcies are among small firms. Small business failures are already high — a mandate would only accelerate this problem.

77X

Recent surveys by various industries indicate that smaller firms tend to offer coverage when they grow or can afford it.

The results of a recent survey by the National Association for the Self-Employed[27] showed that:

1. For those firms not offering health coverage, average profit or owner's salary was $32,000. Eight percent of firms not offering health coverage had a loss in the previous year. Another eight percent earned a profit or owner's salary of less than $10,000.

2. Average revenues for firms that started to offer coverage were $845,000, compared to $232,000 for firms not offering coverage. Average payroll for the firms that started to offer coverage was $104,000, with an estimated average annual salary for a full-time equivalent worker of $15,600. For firms not offering health coverage, the average payroll was $44,000, with an estimated average full-time salary of $7,400.

3. Firms in the survey beginning to offer coverage experienced an average increase in revenues of $186,000 over the past two years, and an average increase in workers of four. Those not offering coverage saw a $39,000 increase in revenues over a two-year period and an increase in workers of one.

Similarly, a National Restaurant Association Survey showed that:

1. More than half of small companies with sales under $500,000 do not provide any health coverage for hourly or salaried employees.

2. Seventy-two percent of restaurant companies with sales of $1 to $5 million provide health coverage for both salaried and hourly employees.

3. Ninety percent of restaurant companies with sales of $10 million or more provide coverage for salaried and hourly workers.[28]

Imposition of an employer mandate will also negatively impact large employers.

1. A mandate may raise costs for large employers.

An employer mandate would most likely require large employers who self insure to purchase mandated coverage. Depending on the structure of the benefits package and the amount of current employer contributions, the mandated coverage could be more costly than what large employers currently provide (this was the case with the AB 350 mandate) and would likely interfere with cost-efficient managed care techniques.

2. Loss of the ERISA exemption could expose all self-insured employers to state mandated benefit laws.

If the necessary ERISA exemption is granted, all self-insured employees may be subject to state mandated benefit laws, which they currently can avoid by self-insuring. This, too, could raise employer costs.

3. A mandate will reduce private sector plan design and flexibility.

A mandate will reduce private sector plan design and substitute the decisions of labor and employee benefit managers with those of government personnel. Employers currently providing health coverage will face plan design changes and restrictions resulting in a loss of flexibility from the perspective of both management and labor. Furthermore, flexibility in the administration and level of managed care programs could be impaired.

4. An employer mandate imposed in California would cause compliance problems for multi-state employers.

A multi-state employer already providing health benefits will face problems complying with an employer mandate. For example, if a mandate law

is passed, a multi-state employer would have to modify its existing plan to conform to the mandate's benefit and eligibility requirements. That would leave the out-of-state component of its plan subject to different requirements that might potentially conflict from state to state. Even assuming that the requirements of different states do not directly conflict, the health plan must adopt a "greatest common denominator" approach, meeting all requirements of each state at a greater cost, or the plan must be administered separately in each state, causing enormous administrative burdens.

The United States Supreme Court has criticized the effect that Hawaii's health coverage mandate has upon multi-state employers. "Whether a state requires an existing plan to pay certain benefits, or whether it requires the establishment of a separate plan where none existed before, the problem is the same. Faced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not pay them at all."[29]

79X

Solution

A Public / Private Sector Solution

Rather than penalizing financially vulnerable small employers and negatively affecting large employers — all for the sake of a quick "fix" to the problem — government and the private sector can combine resources in an approach that addresses the diverse groups that comprise California's 4.8 million people without health coverage. To maximize resource allocation, the first priority of any program to respond to this problem should be to assist the chronically uncovered. While help should also be extended to those who lack coverage because they are between jobs and the like, their plight is different from those who simply cannot currently get coverage because they do not have enough income or due to their medical condition.

Expanding coverage in the small employer market.

More has to be done by both the public and private sectors to provide small businesses with the opportunity to purchase affordable health coverage. Surveys demonstrate that small businesses do provide health coverage to their workers once they can afford it, since such benefits tend to attract a better workforce. Unfortunately, healthcare coverage is currently unaffordable to many small businesses, a situation that is worsening by the day because costs are increasing more rapidly than overall inflation, and the rate of utilization is also on the rise.

Actions must be taken to provide more affordable health coverage for small employers, a more stable market in which to purchase coverage, and incentives that encourage small businesses to buy coverage for the first time.

More affordable coverage is needed.

Currently, California's mandated benefit laws prevent insurers from offering lower cost benefit plans free of some of the state's mandated benefit laws. Making affordable coverage available would allow employers and employees the flexibility and freedom to choose the type of health coverage they would like to purchase.

Moreover, small employers should be provided the very same freedom from state mandated benefit laws now enjoyed by self-insured plans (which typically are used by larger employers). Ironically, small employers — those least able to afford health coverage — are one of the few groups saddled with purchasing these costly mandated benefits.

Carriers should be required to sell low-cost benefit plans to small employers. Ideally, this coverage should be made available to all small employers. Alternatively, such low cost coverage could be offered for a limited time (e.g., four years) as an incentive to small employers not yet offering coverage.

In Denver, Colorado, an experimental program has been implemented which allows small employers to purchase a low cost health plan. Researchers monitoring the program were pleasantly surprised by the high participation rate of small employers and the success of the program to date. (See description of program in Attachment A.) Similar programs are being conducted across the country. Furthermore, states across the country are beginning to pass laws enabling small employers to purchase this "no frills" lower-cost policy.

Additionally, small employers who have, as a majority of their work force, low income employees should be offered a special health coverage plan that is exempt from provider balance billing. Such a plan would be less costly for these low-income employees. While such a plan does not eradicate the uncompensated care problem, it does reduce it by providing payment for a substantial amount of the services provided. Such a plan was recently passed by the Connecticut legislature.

80X

A more stable and predictable marketplace that guarantees availability is needed. Problems exist in the present small employer marketplace that need to be addressed in order to facilitate increased coverage and to provide a more stable market. These problems include difficulties in availability and affordability for small employer groups with high-risk individuals or which are engaged in a high-risk business. Also problematic are high rate increases for small employer groups that have made high claims.

A not-for-profit reinsurance mechanism coupled with the small group underwriting and rating reforms described below is intended to serve several goals. First, it would guarantee the availability of coverage to all small employers, including groups with high-risk individuals. This guaranteed availability will provide the necessary safety net for those employers and employees who are currently experiencing difficulty obtaining health coverage due to existing medical conditions. Thus, the reinsurance mechanism has as one of its goals the same principle as the recently passed AB 60.[30]

Second, the reinsurance mechanism and the rating restrictions would combine to provide a more predictable and stable pricing structure for all small employers, as well as making the coverage more affordable for groups with employees possessing an existing medical condition. Because the vast majority of groups will eventually experience adverse claims, this reinsurance mechanism will provide long term benefits in the form of stable prices. The rate restrictions also will eliminate the large premium increases some employers are currently experiencing.

Although this mechanism would impose significant underwriting and rating restrictions on carriers and radically change the way carriers operate in the small group market, it is supported by many in the insurance industry. It is a necessary response to the problems experienced in the small group market, and it will provide a more stable market for small employers, thereby encouraging them to provide coverage to their workers.

The underwriting and rating reforms needed to achieve the desired stability include the following:

- Limitations would be imposed to eliminate the traumatic rate increases currently levied on some small employers. Two rate limitations should be imposed. First, yearly increases for each risk class should be limited to medical trend (as measured by increases in new business rates) plus a small duration factor. Second, a cumulative rate limit should also be imposed. This could be achieved by imposing a rate corridor on all small group carriers between the carrier's lowest and highest rates for each risk class.

- Carriers would be required to guarantee issue and provide coverage to all small employers who desire it.

- Carriers would be prohibited from cancelling a small employer's coverage except for non-payment of premium, fraud, or failure to meet participation requirements. Individuals who continue to meet eligibility requirements could not be terminated from group plans because their claims are high.

- All carriers would be prohibited from imposing new pre-existing conditions on individuals once they are covered in the small employer market (i.e. when individuals change jobs or employers change carriers).

To ensure the long term viability of these underwriting and rating restrictions and to guarantee availability of coverage to all small employers, a not-for-profit reinsurance mechanism must be established. The reinsurance mechanism would have the following characteristics:

- The reinsurance mechanism will guarantee availability by requiring all carriers writing small group coverage to accept applications on a guaranteed issue and guaranteed renewal basis (i.e., each carrier would be required to "take all comers").

81X

• Each carrier will have the ability to reinsure high-risk individuals with the reinsurance mechanism in exchange for a reinsurance premium. In those cases where an entire group is high-risk, the carrier would be required to accept the group, but would be able to place the entire group in the reinsurance mechanism to purchase the reinsurance product when it is first written. To achieve greater affordability for the small employer, it is essential that carriers be allowed to cede high-risk individuals in the group to the reinsurance mechanism rather than only permitting the ceding of the entire group and having the entire group pay a premium that is higher than the standard premium.

The process of reinsurance would be invisible to the employer group in order to avoid discriminatory treatment and to protect employee privacy. To accomplish these objectives, an employee will not be aware that he or she is being reinsured by a carrier. When a carrier has chosen to reinsure, it will continue to pay the claims for the non-reinsured and reinsured risks. The process of reinsurance premium payment and reimbursement for reinsured risks are purely transactional between the carrier and the reinsurer.

• Naturally, the reinsurance mechanism will incur losses because those in the reinsurance mechanism will be those whose claim costs are expected to exceed the reinsurance premium. The losses of the reinsurance mechanism should be spread equitably back across the marketplace; they should not be disproportionately borne by a few.

There are some differences between this reinsurance proposal and the Association of California Life Insurance Companies (ACLIC) reinsurance proposal.

In many respects, the ACLIC proposal is very similar to the reinsurance mechanism proposed herein. The major differences between the two proposals are the type of mechanism to be implemented (individual versus group) and the issue of whether an employer mandate is necessary to make the mechanism operate correctly.

• Individual versus group mechanism

The group reinsurance mechanism requires carriers to reinsure only an entire group, presumably at some premium above the standard market price. The advantages typically ascribed to this approach include:

Reinsurer losses are limited by the presence of low-risk individuals in the pool;

A smaller number of people are reinsured because it is economically unattractive for the larger small employer (e.g., those with 10-24 employees) to be reinsured.

It is administratively simple.

It is easy to explain.

The disadvantages of the group reinsurance mechanism include:

Guaranteeing availability solely by reinsuring the entire group and forcing the entire group to pay a higher rate is unresponsive to the problems faced by small employers. It does little to respond to the affordability problem faced by these employers.

The group reinsurance mechanism is unattractive to "larger" small employers who would pay a significant portion of the pool losses through higher rates, but who would have little opportunity to use the reinsurance due to the higher cost of reinsuring the entire group.

A new entrant to the group who is in poor health would seem to allow the carrier to reinsure the whole group, despite contractual obligations.

It acts to discourage employers from hiring individuals with significant health problems (or those with dependents in poor health).

The pool losses are lower under the group design because many standard risk individuals are pooled with high risks. Furthermore, the subsidy for high-risk individuals comes disproportionately from employers with high risks and their employees.

The individual reinsurance mechanism allows the ceding of high risk individuals at a rate above the standard premium, but charges the other individuals in the group a standard rate, thereby containing the cost of reinsurance. The advantages of this mechanism include:

A small number of the highest-risk cases are reinsured, but no standard risks are reinsured, thereby limiting the number of people in the pool.

High-risk individuals who are new to an employer group are easily accommodated.

This mechanism is responsive to the concerns expressed by small employers because it spreads the cost of the higher-risk individuals across the entire market, thereby minimizing the cost of providing coverage to these individuals, rather than requiring a small group of employers to bear a disproportionate cost burden. It also provides the small employers with a more affordable alternative than is offered under the group approach.

While individual reinsurance is somewhat more complex than is preferable in a perfect world, many of the details are necessary to prevent any carrier from "gaming" the arrangement to its benefit and to the detriment of other carriers and small employers. Furthermore, the complexity permits reinsurance to be made available equitably to groups with between 10-24 employees, in addition to employers with fewer than 10 employees.

Disadvantages of the individual approach include:

It is administratively more complex than the group approach.

It is harder to explain.

On balance, the individual approach, which presents the greater opportunity for more affordable coverage and the equitable treatment of all small employers, seems far preferable to the group approach.

• Does the reinsurance mechanism require a mandate?

The proposed individual reinsurance mechanism does not require an employer mandate to operate effectively. However, the ACLIC proposal is predicated on an employer mandate, presumably based on the fear that absent a mandate only the "unhealthy" groups will purchase coverage, which in turn may cause serious reinsurance losses. An actuarial analysis which examined this hypothesis demonstrates that this fear is unfounded.

A mandate is not necessary to ensure the viability of the reinsurance mechanism. First, the 12-month pre-existing condition limitation still applies to groups entering the system for the first time. Thus, there is a disincentive built into the system for groups to purchase coverage only after they "get sick." Secondly, and most importantly, an actuarial analysis has been conducted which examines the hypothesis relied upon by ACLIC. This analysis demonstrates that in a *worse case scenario*, where the only groups that enter the insurance market are the reported 17% of uninsured small employers who indicate that they cannot obtain coverage (as opposed to not being able to afford it), overall rates would be raised only 3-6%. Of course, if employers with standard risks also purchased coverage, the rate increase would be less than 3-6%.

83X

Broad tax credits are needed.

A broad-based tax credit should be implemented for small employers (including the self-employed) that provide health coverage to their employees. The passage of SB 1207 in 1989 was a step in the right direction. However, in order to best satisfy the goal of encouraging small employers to provide health coverage to their workers, the legislature should amend that legislation to provide a broader-based tax credit that is not linked to the specific (and expensive) benefits package outlined in AB 350.

Greater cost containment is needed

In order to achieve greater affordability of health coverage, more needs to be done to contain costs. The following measures are all areas that should be seriously examined for potential cost savings.

- Data collection - California should require collection of uniform out-patient provider specific data. Currently, the Office of Statewide Health Planning and Development collects inpatient hospital data. This data should be collected from providers. Collecting the data from a third party, such as the insurance industry, will not be as accurate or efficient.

- Tort reform - Tort reform measures, such as those put forth in the AB 350 Task Force Report, should be part of any cost containment effort. One component of the increased cost of medical care is the direct cost of malpractice insurance and the cost of defensive medicine. Reforms in tort laws could aid in controlling these costs.

- Remove the ban on the employment of physicians - California is only one of two states that prohibits employment of physicians. California should join with the other 48 states by removing this ban.

- Increase the rates paid to providers for Medi-Cal services - The vast bulk of the cost shift paid by private payers is caused by the underfunding of the Medi-Cal and Medicare programs. The cost shift would be greatly reduced if providers were adequately paid for their participation in these programs. Furthermore, increased payments would help alleviate the current unwillingness of many providers to participate in Medi-Cal. Adequate funding of government-sponsored programs such as Medi-Cal would be far more effective in eliminating the cost shift problem than would an employer mandate.

- Expansion of managed care - Both insurers and businesses have been active in developing a variety of managed care programs aimed at containing costs. Insurers and businesses should be encouraged to continue development of these innovative techniques. The legislature can help in this effort by refusing to pass legislation that inhibits the development of managed care.

Public assistance for low-income people without health coverage

The proper role of government, and the first priority of a program for the uncovered, must be to provide coverage to low income individuals through carefully targeted, improved, and expanded public assistance programs, including but not limited to the Medi-Cal and MIA programs. Governmental assistance to the poor and near poor could take several creative forms and could involve public/private cooperative efforts. The suggested forms of public assistance outlined below are just that—suggestions. Input from all interested sources would be of great assistance in developing creative and innovative public assistance programs and is encouraged.

Expand public assistance programs to provide coverage to all of the poor.

Eligibility for public assistance should be broadened to ensure that all persons who fall below the poverty line are covered, irrespective of age, disability, family or employment status. Such an expansion would provide coverage to the 1.4 million uninsured Californians with an income level below poverty. Expansion of coverage could be achieved through expansion of the Medi-Cal program. However, it is likely that the same goal could be achieved in other ways, including programs linked to the county hospitals.

84X

Allow the near poor access to Medi-Cal. Next, creation of a broad public assistance option that would enable the near poor (e.g., family income from poverty up to 150% of poverty and with limited assets) to pay an income-related premium for a limited set of out-of-hospital, primary, preventive and ambulatory services covered on a first dollar basis. A sliding scale of premiums would be developed so that, at the upper end of the income range, the charge would approximate the actuarial value of the coverage.

The benefit package would provide for primary and preventative care and would include basic ambulatory services such as well-child care and immunizations, pre-natal care, basic diagnostic services, including laboratory tests and x-rays, primary treatment services, monitoring of chronic illness, and outpatient prescription drugs. Such a limited benefit package meets the near poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment). The fiscal impact of the public assistance option would be significantly less than expansion of full Medi-Cal coverage.

To assist people with extraordinary expenses, those who are otherwise ineligible for Medi-Cal (for income reasons) should also be permitted to obtain full Medi-Cal coverage once their out-of-pocket medical expenses reduce remaining income to the federal poverty level.

Encourage development of public/private cooperative efforts, including a buy-out. The poor and near poor who are working should be encouraged to make use of employment-based coverage where it is available. The 1988 federal Welfare Reform Act allows the public and private sectors to work together to provide coverage to low-income workers with use of a "buy-out". Under the buy-out concept, the state would be permitted to pay a poor or near poor employee's share of the private coverage premium (or some portion thereof, depending on the income level). For those employees who would otherwise be eligible for Medi-Cal coverage, Medi-Cal would continue to be available to cover deductibles and other benefits not covered under the employer's plan. Medi-Cal's contribution for the employee's premium plus Medi-Cal's "wrap around" coverage would not be permitted to exceed the average cost of traditional Medi-Cal coverage.

With the implementation of a buy-out, low-income workers are provided with the opportunity to enroll in a private plan. Furthermore, the state is given the opportunity to reduce the number of people in public assistance programs and to encourage the low-income employed to take advantage of employment based coverage. This program also has the collateral benefit of improving the interface between public and private forms of coverage.

The provision of low cost prototype plans and the Medi-Cal wrap-around are not new concepts in California. Four years ago, the Department of Corporations licensed a prepaid Knox-Keene plan to use a benefits package that was below the regulatory benefits level of the Knox-Keene regulations. The restrictions were primarily in the form of caps on amounts that could be paid for certain high expense items. The alternative to this low cost plan for some was either Medi-Cal or no health coverage.

The results of this plan are startling. Only 0.23% of the enrollees on an annual basis exceeded the caps. Had the caps not been imposed, the premiums would have been 40% higher to cover the expensive overages. More than 7,000 people were able to obtain coverage who otherwise would not have had any. Many of these are in the category of the "working poor". In this program, like the buy-out, the private sector is used for the bulk of the care, but backed up with a public program. Innovative programs to provide coverage to those without it, including the low cost plan, the Medi-Cal wrap-around, and the buy-out should be encouraged and expanded.

85X

End Notes

1 California Policy Seminar "Californians Without Health Insurance," September 1987. (Hereinafter California Policy Seminar Report.)

2 U.S. Bureau of the Census, Current Poplulation Reports, series p. 70, No. 17, Health Insurance Coverage: 1986-88; U.S. Government Printing Office, Washington, D.C. 1990. (Hereinafter Census Bureau report.)

3 Census Bureau report. Please note, although the actual number of uncovered Californians is inaccurately reported in the California Policy Seminar Report and there are other flaws in this report, there appears to be validity in the proportions of uncovered individuals reported in that report. Therefore, these proportions will be relied upon in this paper.

4 California Policy Seminar Report, p. 6.

5 A. C. Monheit and C. L. Scheer, "Examining the Dynamics of Health Insurance Loss". Paper presented at APHA Annual Meeting, October 20, 1987, Table 5.

6 Employee Benefits Research Institute, *Issue Brief*, 66 May, 1987, p. 9. (Hereinafter EBRI.)

7 Census Bureau report. See also P.M. Danzon and F.A. Sloan, *Covering the Uninsured*, Vanderbilt Institue for Public Policy Studies, December 1986, p. 4.

8 California Policy Seminar Report, p. 5.

9 *Ibid.*

10 U.S. House Committee on Small Business, "The Health Insurance Problem: Alternative Strategies To Expand Coverage Among Small Business", 100th Congress First Session, 1987 at 15. (Hereinafter CSB Report.)

11 California Policy Seminar Report, p. 23.

12 EBRI, p. 5.

13 CSB Report, p. 3

14 CSB Report, p. 3.

15 CSB Report, p. 21.

16 CSB Report, p. 3.

17 California Policy Seminar Report, p. 23.

18 California Policy Seminar Report, p. 20

19 California Policy Seminar Report.

20 National Federation of Independent Businesses, July, 1989.

21 CSB Report

22 CSB Report, p. 3

23 CSB Report, p. 13.

24 CSB Report, p. 13.

25 National Federation of Independent Businesses, July, 1989.

26 Public Policy Institute, *Cure or Cause?*, July 1989, p. 28.

27 National Association for the Self-Employed, *Increases In Health Insurance Coverage Among Small Firms, 1986- 1988*, July, 1988.

28 Statement of W. W. Naylor, President of American Restaurant Services, Inc. on behalf of the National Restaurant Association before the Senate Committee on Labor and Human Resources. June 23, 1989, p. 5.

29 *See Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2218 and n.7 (1987).

30 The legislature should be commended for the passage of AB 60, the uninsurable risk pool legislation, which makes coverage available to individuals whose medical conditions make them uninsurable. The uninsured population should decrease as a result of this legislation.

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NEW JERSEY BUSINESS & INDUSTRY ASSOCIATION

STATEMENT TO THE

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

JULY 18, 1990

847

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

Thank you for this opportunity to present, on behalf of the New Jersey Business & Industry Association, some of our concerns and suggestions for reform with regard to health insurance.

HEALTH INSURANCE COVERAGE

The Notice for this Public Hearing raised three important questions for the businesses and citizens of New Jersey. The first question, concerning what services should be covered under health care insurance, goes to the heart of the purpose of the health care delivery system. It is generally recognized that, in contrast to other western nations, a disproportionate share of our health care dollars are spent on acute and terminal care. We believe that it is necessary for government to take a leadership role in sponsoring research to identify the preventive care services which are cost effective and which should be encouraged as part of health insurance plans. The Federal Government has recognized this need by requesting $110 million in FY 1991 funding for research on medical effectiveness and patient outcomes.

New Jersey's citizens have a right to an impartial review of the effectiveness and efficiency of the health services which are available to them. New Jersey's Department of Health should follow the lead of the U.S. Department of Health and Human Services by becoming the

catalyst for physican groups working to reach concensus on practice patterns that provide a high quality of care at an affordable cost. Such an impartial review would provide much needed guidance to insurers and consumers in their purchasing decisions. The results should also be used to judge the validity of claims put forth by health care providers who have a vested interest in expanding health insurance coverage to include their specialty.

I also urge this Commission to remember that providing access to health services is not the same as guaranteeing a healthy population. Health insurance is only a payment mechanism. It is the individual responsibility of each of us to maintain a healthy lifestyle to the best of our genetic and economic ability. I urge you to consider how public funding for nutrition, housing and public health eduction is as important to our health as access to treatment settings. Health insurance coverage is not a panecea for the shortcomings of our society which lead to the spread of AIDS, an increasing number of "crack" babies and a high incidence of heart attacks and lung cancer among smokers.

OBTAINING HEALTH INSURANCE

Affordability is the key issue which we urge you to address when considering how to improve the prevalence of health insurance coverage. The newspaper headlines over the past several years, which reported health insurance rate increases of 20, 30 and even 60 percent, would scare any business person away from the market. Business people who do

not provide health insurance are not "bad" or "irresponsible". They are reacting logically to a system which is clearly out of control. Governor Florio has recognized this fear and sense of helplessness on the part of individual businesses by forming his Commission on Health Care Costs. Resolving the affordability issue will require a package of reform measures.

A number of reforms should focus on the underwriting practices of the health insurance industry. I commend to your attention the recommendations from the Health Insurance Association of America which would change underwriting practices. Their recommendations include: Eliminating the ability of employers and insurers to exclude an individual from a group's coverage because they present a high medical risk; Assuring groups that coverage will not be cancelled at policy renewal time because of deterioration in the health of the group; and Setting specific limits on how much a private insurer's rates could vary for employer groups of similar composition.

Other reforms need to focus on the underlying high cost of health care. Current trends in the private sector are toward health plans which actively manage both the fees paid to providers and appropriate levels of utilization. Whether called health maintenance organizations, preferred provider networks or other hybrid terms, over 90 percent of New Jerseyans are expected to be in such plans by the year 2000. We believe that only by dealing up front with sensitive questions of freedom of choice and quality of care is there any hope a modifying the seemingly unlimited demand for health care services. As

a major purchaser of health care services for both state employees and Medicaid recipients, State government in New Jersey can encourage the trend toward managed care by restructuring its own plans.

We have also been informed that the development of Multiple Employer Trusts have been hampered in New Jersey by an existing law which covers minimum group size for life insurance plans. Because many insurers provide a package plan of both life and health insurance, a 10 person minimum under the life insurance law limits the ability of insurers to form METs for very small groups. The Department of Insurance has informally indicated that this problem would be a relatively simple matter to correct legislatively.

Other states have shown leadership in providing incentives for small businesses to enter the health insurance market. Washington and Virginia have passed laws to exempt small group polices from state health benefit mandates in order to lower premiums. The city of Denver, under the auspices of the Robert Wood Johnson Foundation, began last August to offer a small business health plan that incorporated preventive care and catastrophic coverage at reasonable rates. In all cases these governments are trying to address the need for affordable health plans in the small business market.

MANDATING HEALTH CARE COVERAGE

The Health Affairs Committee of the New Jersey Business & Industry Association recently reviewed the Association's long-standing position with regard to mandated health insurance. This Committee reaffirmed its opposition to government mandated health insurance coverage. As noted above, affordability of health insurance is the key issue and until the upward cost spiral is brought under control, it is illogical to expect small businesses, with limited resources, to purchase health insurance.

Small and medium-sized businesses are at a disadvantage in the health insurance market because they cannot self-insure in order to tailor their plans to their available revenues and the needs of their employees. Cost control strategies also have limited success in this market because there is an inadequate user base to justify the up-front costs of such services as utilization review, preventive programs and second surgical opinions.

Any mandate would have a negative impact on employment in New Jersey. If a mandate covered only full time workers, both large and small employers would increase their number of part-time positions. If part-time workers were included under a mandate, the number of part-time and entry positions would be decreased. In either case, because health benefits are so expensive, employers would have to adjust their employment levels to remain competitive with other states and

countries. The recent series in the Star Ledger highlighted the importance which retaining existing jobs has on New Jersey's slowing economy. We cannot function as an island unto ourselves and increase labor costs out of line with the rest of the country.

DENVER BUSINESS JOURNAL
AUG 21, 1989

221

SCOPE to unveil small-firm health plan

By SHARON McEACHERN

A new health insurance plan for small businesses — the first of its kind in the nation — will be introduced tomorrow to Denver-area employers.

The Shared Cost Option for Private Employers, or SCOPE, has been under development for two and a half years in a cooperative effort by government agencies, non-profit groups and the private sector.

Judy Glazner

Underwritten by United States Life Insurance Co., a subsidiary of New York-based U.S. Life Corp., the SCOPE plan is designed to provide affordable health care to the thousands of employees of Denver small businesses that currently are unable to offer health insurance coverage.

An estimated 90,000 adults in the Denver area have full-time jobs which do not offer health insurance. The number of uninsured Denver residents affected leaps to a staggering 250,000 when spouses and dependents are added, according to a SCOPE project survey.

"It took us several years to assess the needs in the small-employer population that can't afford health insurance and to find an insurance company that was interested in underwriting this perceived-to-be high-risk market," said Judy Glazner, SCOPE project director, who works out of offices at Denver's Department of Health and Hospitals, one of the project's backing agencies.

"In our survey, we found evidence that Denver's small- business employees are not high risk, but just the opposite," Glazner said. "They are young, with 50 percent under 35 years old, and predominantly male."

Insured groups with a large concentration of women in their childbearing years are considered high risk, she added.

Describing the new health insurance plan as "a kind of hybrid," Glazner said the SCOPE coverage is a cross between a health maintenance organization and catastrophic health insurance.

"It's like an HMO plan, where you can get reasonable preventive and primary care at very little out-of-pocket costs, and an insurance plan protecting you against financially catastrophic health events."

The SCOPE policy will be offered only through employers that have 50 or fewer employees, and self-employed entrepreneurs will qualify.

"There is no coverage like this in the world," Glazner said. "Typically, most health insurance policies have annual deductibles, where persons covered must spend money before getting any benefits at all.

"This plan has no deductible unless you go into the hospital for treatment," she added. "In comparison, most health insurance plans that provide you with anything more than catastrophic benefits cost around twice as much."

The uniqueness of the SCOPE plan makes cost comparisons with other employer-provided health plans difficult.

However, U.S. Life Senior Vice President Hugh Bailey offered the following example using the company's other managed-care products:

"For each $100 it costs to insure an employee under our most comprehensive plan, it costs $74 under our most conservative plan and $44 for the SCOPE plan. That's a 66 percent reduction off a plan that pays 100 percent of everything."

U.S. Life already was developing low-cost health plans when it was contacted by SCOPE representatives.

"One of the reasons we were interested in underwriting the SCOPE plan is that we believe one of the largest problems our industry faces is the growing number of working uninsured in the U.S.," Bailey said. "The SCOPE project people approached us as we were bringing to the market a new series of indemnity products which were designed to shift some of the first-dollar costs to the employee, resulting in dramatic reductions in cost to the employer. "Carrying that technology forward, it seemed a natural fit for us in Colorado," he added.

The plan's contracted provider network includes 1,600 physicians and 12 hospitals in the metropolitan area. Based on preventive care, the policy provides 100 percent reimbursement for such services as periodic physicals, well-child care, mammography screenings and immunizations for children.

Visits to a doctor, for other than preventive care, will cost an employee $15 out-of-pocket.

Although deductibles are absent for primary care, there is significant cost-sharing if an employee has to go into the hospital for treatment. Hospitalization includes a $250 deductible and coinsurance of 50 percent up to $5,000, after which coverage is 100 percent.

Small-business representatives reacted favorably to the plan.

"We're very supportive of the SCOPE project and believe it can fill a critical need," said Ron Smith, state director for the 14,000 Colorado members of the National Federation of Independent Business.

"Most small employers cannot afford to get basic health plans that focus on major medical and catastrophic health care, let alone the 'Cadillac' plans. They are just priced beyond the reach for small employers, whose rates are more than 30 percent higher than larger employer groups."

"The survey shows that in many cases the added cost of health insurance would be enough to tip the balance for many small-business owners who would find it financially advantageous to close and go to work for someone else," Smith said.

Another statewide survey, conducted last year by Louis Harris Associates, found that 11 percent of Coloradans failed to obtain health care services they felt they needed at some time in the previous year. This was the highest percentage the firm found in any state. . .

The majority of Denver's small businesses qualify for coverage under SCOPE, but some are excluded, including high-risk employers in hazardous industries, such as mining companies, explosives manufacturers, asbestos workers and exterminators. Pawn shops do not qualify nor do some service industries with high employee turnover, such as bars and taverns.

SCOPE project sponsors

SCOPE was developed through a cooperative effort of the following organizations:

Denver Department of Health and Hospitals
Robert Wood Johnson Foundation
Colorado Trust
Piton Foundation
Hill Foundation
University Hospital
Denver Medical Society
Colorado Business Coalition for Health
Colorado Association of Commerce and Industry
Colorado Hospital Association
Colorado Medicaid Program
Greater Denver Chamber of Commerce
National Conference of State Legislatures

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States Test Bare-Bones Health Insurance

By JEANNE SADDLER
Staff Reporter of THE WALL STREET JOURNAL

States are doing more to encourage small businesses to provide health insurance voluntarily.

In Virginia, Washington and Florida, new laws permit experimental, limited coverage for small companies that don't already offer health benefits. Connecticut recently passed a law that temporarily reduces rates for such small firms and establishes a pooling arrangement to cover people with existing medical conditions. Other states are starting still more programs.

While an estimated two-thirds of small businesses nationwide offer health coverage, more than a third of the nation's approximately 31 million uninsured people are affiliated with small firms. And rates are going up for those companies that do offer coverage. According to a survey early this year by National Small Business United, a Washington-based group, insurance rates increased between 16% and 35% this year over last for 38% of the business owners polled.

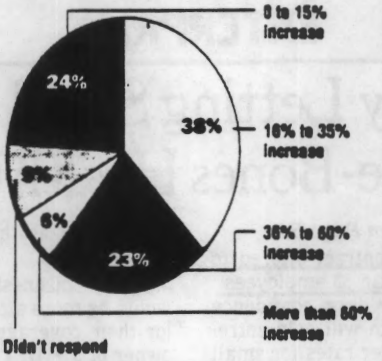
To cut costs, the new laws in Virginia, Washington and Florida exempt the bare-bones small-group policies from state mandates to cover certain medical treatments. The insurers can instead offer coverage for hospitalization and basic physician's care. State laws requiring carriers to cover such items as treatment for drug or alcohol abuse, mammograms and psychiatric and chiropractic care can raise rates by 17% to 20%.

'Squared-Away People'

Some small-business owners are enthusiastic. Gerald Roscoe hasn't been able to afford health insurance for employees at his two-year-old general contracting firm in Lexington, Va. "I own the bloody company, and I'm not insured," he says. But he's interested in Virginia's new program. "To grow, we need to attract squared-away people who are responsible with their lives," he says. "One of the ways we can do that is by offering health insurance."

Higher Premiums

The percentage of surveyed companies that said their health insurance premiums rose this year within these ranges



Source: National Small Business United

Because the laws just took effect, insurance companies are still drawing up specific plans. Blue Cross and Blue Shield of Virginia, which offers about a third of all policies in the state, will begin marketing its basic health plan next month. It's expected to cost eligible small employers about $80 a month per worker, compared with an average (for all carriers in the state) of about $130 monthly per employee. The company has added a limit of $50,000 in medical expenses per calendar year to further lower the cost. To qualify, a company can't have offered employees health coverage for the last year.

Similar plans are cropping up in other states as well. Blue Cross companies in Oklahoma and California recently started offering small groups bare-bones lower-cost insurance policies, says Gregory Scanlon, director of Blue Cross Blue Shield Association, which represents 74 independent, nonprofit state insurance plans. In Oklahoma, the policy costs from $22.50 a month for those under 19 to $123 monthly for people 64 and older.

"It's a step in the right direction," says Thomas Inman, president of Virginia Home Medical, a Newport News, Va., medical supply company that already provides health insurance for its workers. But he warns that the price of even a bare-bones policy may be high for a company with a history of medical problems. Health insurance rates for his company shot up 62% this year, to $26,000 annually for 22 workers, he says. The rates skyrocketed after the wife of one of his employees contracted cancer and diabetes.

Impossible to Afford

Small businesses that already offer insurance say such steep rate increases can quickly make the benefit impossible to afford. Mr. Inman says if his health insurance rate nearly doubles again, he'll have to drop the benefit.

Typically, small employers lack access to insurance from any carrier if they don't have many employees or one of their workers already has a condition requiring medical care. IMSCO, a Newark, Ohio, company with four employees, lost its hospitalization policy after one employee had seven major operations to correct a life-threatening condition and the owner had heart bypass surgery. "Nobody wanted to cover us. One insurance agent even got mad that he had wasted time coming out to our office," says the company's president, Gary Stansbury. The group finally got insurance when a health maintenance organization accepted the group by mistake and couldn't legally reverse the decision.

Regulators and small-business officials are optimistic that the experimental programs will lead to broader efforts both to hold down costs and to increase coverage. "This is one step that's the first of many, but it can immediately show results," says Gary Smith, director of the Independent Business Association of Washington state. He says small firms with fewer than 10 workers in the state now pay 40% more for

Please Turn to Page B2, Column 3

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States Try Letting Small Concerns Offer Bare-Bones Health Coverage

Continued From Page B1

the same health care contract offered to businesses with more than 50 employees.

There's considerably less confidence that the Connecticut plan will help entrepreneurs. There, the lower rates for small businesses will result partly from an agreement that hospitals and other health care providers will accept less money over the next three years to care for the newly insured patients. And all companies will pay into the fund covering those with poor health.

"This [legislation] will guarantee that for a limited period, everybody working in Connecticut will be able to acquire coverage at some price," says John Polk, executive director of the Council of Smaller Enterprises, a Cleveland group that purchases health insurance for its member companies.

But he charges that the law will allow steep rate increases and require inclusion of all state-mandated medical care. "It's my sense that what insurers are intending to do here is not change the way they do business but change the way they explain their current behavior," he says.

The National Association of Manufacturers says most of its members with fewer than 25 employees offer health insurance. "Affordability is more the issue for them," says Sharon Canner, the association's health policy director. "There's some belief that costs could go up [under the Connecticut plan] because all employers contribute to the high-risk pool."

Mr. Scanlon of Blue Cross Blue Shield Association agrees that the Connecticut plan is unlikely to reduce rates. "I'm concerned that after a couple of years, policy makers will say, 'Where's the result?' They'll feel as though they've been misled," he says.

Many businesses say the insurance would be more affordable if they could tailor their coverage. Diane Orlowski, a co-owner of J.F.D. Tube & Coil Products Inc. of Hamden, Conn., complains that she must provide coverage for maternity care and counseling for drug abuse and psychological problems even though the services are rarely used by her 22-member work force.

"I get a lot of raised eyebrows when an employee leaves and I ask them if they want to continue their health insurance on their own," she says. Under a 1986 federal law, workers have the right to extend coverage. Ms. Orlowski says that because of the expense, her employees rarely extend their health coverage.

Despite the doubts, the Health Insurance Association of America says the Connecticut law reflects many of the principles governing service to small groups that it adopted early this year. At that time, the industry trade group said that it favors limits on how much rates can vary for similarly situated companies; establishing a national, nonprofit reinsurance mechanism to pay medical bills for high-risk individuals; and an end to significantly increasing a company's insurance rate because one worker has a health problem. The National Federation of Independent Business, the Chamber of Commerce, the Association of Manufacturers and National Small Business United support those proposals.

"There's no instant solution; it'll take three years," Carl Schram, the insurance association's president, says of the Connecticut program. "But we go into this with great hope that it'll operate to solve the problem."

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N.J. Industrial Union Council, AFL-CIO

At the outset, the committee recognized that any state-based reformation of health care policies would, necessarily, encompass deficiencies which could be addressed only in a national policy. Nonetheless, no federal action on a national health program is imminent and New Jersey cannot wait. The needs of our citizens are real and urgent.

The committee elected to begin by adopting a set of principles to guide its work. We then sought to apply those principles to recognized problems in our health care system. We did not attempt to address every problem nor do we believe we have arrived at "the" solution. We are however convinced that implementation of our proposals would significantly narrow the rapidly expanding "gaps" in our health care delivery system in two crucial aspects: access and cost. Our first recommendation is to make access to sufficient health care available to all citizens by strengthening and expanding our system of employment-based health insurance. The other, equally important, is to reform the way we pay for health care costs through use of a single payer method, so as to bring those costs under control. It is the judgment of the committee that these factors are inseparable; no real reform can occur without action in both areas.

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IUC STATEMENT OF HEALTH CARE PRINCIPLES

1. All citizens of New Jersey should have access to sufficient health care, regardless of economic or employment status.

2. We oppose the use of co-payments, deductibles and other so-called "cost sharing" measures which act as a barrier to health care. (Health care includes currently mandated benefits such as alcoholism treatment and mental health services.)

3. Our State's health policy should emphasize preventive care and health education. Special emphasis should be given to developing a plan to expand and finance long-term care and home health care.

4. Health care consumers must continue to have choice of provider.

5. We must reform our method of paying health care costs so as to control cost increases and to effectively manage our limited health care resources.

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At the present time, more than a half-million New Jersey residents are without any health insurance coverage. Many more have insurance which limits the type of care covered. The explosion of practice of "cost-sharing," through the use "shared" premiums for health insurance, greater deductibles and increased co-payments have put necessary, basic health care services out of reach for many New Jersey workers who are insured. Although cost-sharing is often touted as a cost control method, cost-shifting, to use a more accurate term, has little or no effect on overall health care costs.

It is probably not possible to calculate, with any degree of precision, how much we now spend on health care in New Jersey. But our current hodgepodge of coverage is designed to pay the costs of sickness--not health.

Pregnant women who cannot afford prenatal doctor visits which might cost $500 - 600 will have more premature deliveries, longer post-delivery hospital stays for mother and infant, and a significantly higher rate of birth defects.

The child with asthma, whose parents can't afford regular doctor visits and prescription costs, winds up in our emergency rooms where costs of medical care are five times higher.

99X

The adult worker with untreated hypertension needs a $6,000 hospital admission to get his blood pressure under control. We could have treated him in an out-patient setting for $40 a month--and he needn't have missed a day of work.

These are everyday occurrences in our hospitals. Unless you're old enough for Medicare, poor enough for Medicaid or just plain lucky that your union or your employer provides good insurance benefits, you're likely to be one of the thousands whose health gets no attention and whose sickness will mean financial and emotional ruin.

Who pays these costs? Many employers pay insurance premiums for their own workers and pay again for uncompensated care. Our federal and state taxes subsidize these costs. Workers share insurance premiums, suffer co-payments and deductibles and pay for medical services not covered by their insurance. Seniors pay medicare deductibles, co-insurance and the premiums for Medicare supplement insurance. Twenty percent of our social security payroll tax goes to fund Medicare and general tax revenues support the federal and state share of Medicaid.

Still, whether coverage is provided through collectively bargained plans or employer sponsored benefits programs, most insured New Jerseyans obtain health coverage through their employment. We propose to use the present employment-based system of coverage as the foundation for a system of universal coverage.

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Under our proposal, all employers in New Jersey would be required to provide basic health insurance benefits or to contribute to the cost of providing the same basic benefits package through a state plan (as with TDI, for example). The state plan would provide the basic benefits package for all uninsured residents, regardless of their employment status. In addition, the state plan would provide catastrophic coverage for all citizens, regardless of the source of their basic benefits package.

COST CONTROL THROUGH A SINGLE PAYER

Expanding health care coverage, without addressing how we pay for our health care, would exacerbate the seemingly endless, upward spiral of health care costs. We must reform our method of paying for health care if we are to gain any measure of control over where and how we allocate our finite resources.

We propose a single payer system such as that envisioned in New York's UNY*CARE proposal. Under this system, a single payer authority (the state or its agent) would be responsible for all payments to all providers of covered health services. The authority would, in turn, bill the appropriate third party payer for each patient. Providers would only bill patients or third party payers for non-covered services.

This change alone would result in significant savings in billing and administration costs. Providers would no longer face multiple payers, each with its own billing procedures, claim forms, payment criteria and reimbursement rates. Unpaid and uncollectable bills for basic health care services would be eliminated.

In addition, the single payer authority would determine fair, uniform rates of reimbursement for all providers of all covered services. These reimbursement rates would, we propose, be negotiated with providers, with appropriate adjustments for economic, geographic, demographic and other relevant factors. By establishing a single rate for a covered service, we will thus be able to manage the growth of health care costs and to allocate our limited health care resources more efficiently.

To pay for expanded coverage, we would combine existing funds, new revenues and anticipated savings.

Current Funds

- Medicare
- Medicaid
- PAA
- Grants and subsidies
- Direct program funds

New Funds

- Increased Federal Funds from the expansion of Medicaid coverage
- Employer premiums to state plan to cover uninsured workers
- Unemployment insurance contributions surtax

Savings

- Administration: elimination of multiple billing procedures: streamlined enrollment and claims; coordination of benefits, etc.
- Negotiated payment rates for all providers
- Limit liability of private insurance
- Eliminate uncompensated care charges
- Restraining cost growth

Conclusion

We have had and continue to have our share of problems in New Jersey--from automobile insurance, to school funding, to protecting our environment. Developing a consensus around solutions to these issues has been difficult to impossible.

We expect that solutions to our health care crisis will come no easier. Some will tell you to reduce benefits or to shift more costs. Others will say that real reform is too difficult or too costly. We need you to tell them they're wrong.

Our health care system needs more than a band-aid; it needs major surgery--before it's too late. Every day that passes costs lives and raises the price of any eventual solution.

People are dying for health care reform in New Jersey.

103X

IUC Health Care Committee

John Ronches
Committee of Interns and Residents

Victor Garcia
District 1199-J

Rosalie Griffiths
CWA, Local 1009

Patrick Tully
OPEIU, Local 32

104X

NEW JERSEY FOOD COUNCIL

TESTIMONY BEFORE THE
ASSEMBLY HEALTH CARE POLICY COMMISSION

JULY 18, 1990

BARBARA McCONNELL
PRESIDENT

On behalf of the New Jersey Food Council (NJFC), I want to thank you for allowing me the opportunity to testify before the Assembly Health Care Policy Commission.

NJFC is a non-profit association conducting programs in research, education and public affairs on behalf of its 300 members --food retailers, wholesalers, and manufacturers doing business in New Jersey. NJFC members operate approximately 2,000 retail food stores, with a combined annual sales volume of $10.3 billion.

In looking at our state's health care delivery system, NJFC starts with the following two premises:

- It is unacceptable for any American to be denied quality health care because he or she is unable to pay for it, or because he or she lacks health insurance.

- The cost of health care, and of health insurance, in New Jersey, and across the country, is unacceptably high and is rising at an unacceptably rapid rate.

We agree that both of these problems must be addressed. But in our view, it is inescapable that the access to care problem is a function of the cost problem, and that we will not be able to resolve the access issue until the cost issues are adequately resolved.

Over 60 percent of those currently without health insurance are in households with incomes below $20,000 per year. These individuals lack health insurance, and care, because it is simply too expensive to obtain. Many other Americans in households with even higher incomes are unable to afford coverage or, in some cases, are unable to obtain coverage at any price.

Therefore, we strongly urge the Assembly Health Care Policy Commission to focus its recommendations on the flaws in the existing delivery and insurance systems which have brought us to this place. Although we don't pretend to be experts in health care, any employer in America knows the importance of examining possible solutions as they would affect our industry.

There are a number of areas which would seem to offer opportunities for meaningful cost controls. Ideas for study

include reform of medical malpractice laws which now encourage unnecessary procedures; reform of insurance underwriting practices for businesses and individuals to permit small businesses and individuals to purchase coverage at reasonable rates; the further promotion and development of national medical practice standards to assure appropriate and effective care; the rising cost of new technologies and alleged hospital overbedding; and errors in hospital billings that often times cannot be deciphered by businesses who audit their bills because of a hospital's coding system.

But the essential cost control issue that is most critical to our industry, is the trend towards mandatory health care costs to employers.

These proposals fall into three general categories: (1) laws mandating payment for services of a specific provider; (2) laws mandating coverage of specific illnesses or treatment methods; and (3) laws that mandate a specific coverage level.

Mandated health insurance benefits have been an issue at the state level, as well as the federal level. According to an in-depth article in the Wall Street Journal, during the past twenty years state governments have imposed nearly 700 mandates requiring employers who offer their employees group

health insurance to include specific benefits. What started out as an effort to eliminate token insurance plans has steadily been embellished to the point that inappropriate additions have steadily increased costs, and discouraged some employers from attempting to provide health insurance at all.

Some examples can be found in the roster of bills pending in the New Jersey Legislature, which include a whole range of coverage for additional services, such as including acupuncture, etc.

The adding of some of these services in many cases are due to the efforts of those who provide them. According to the former chairman of New Hampshire's licensing board of psychologists, the number of practicing psychologists in the state surged after a 1976 law provided insurance benefits for their services.

In Maryland, a state with 32 such mandates in its law, a study showed that these provisions increased the cost of coverage by 12%. Another study, by the National Center for Policy Analysis, estimates that 25% of the 37 million people in this country not now covered by health insurance probably would be insured were employers not scared away by the expensive mandated benefits provision in state law.

The irony of the situation is that employers who provide health insurance are then subject to regulations as to what specific benefits they must provide. On the other hand, employers who offer no health insurance are not going to be affected.

Larger employers have sometimes set up their own funds to insure employees. Under federal law, these plans are exempt from state mandates and from state taxes on health insurance premiums. Small employers, however, generally can't afford self-insurance.

The muddled situation at the state level portends what will likely occur at the federal level, should legislation which was pushed in the last session of Congress be enacted. These bills mandate that all employers provide a specified level of health insurance for all employees. Before the ink was dry on the original proposal, the bill was amended to add additional types of insurance to the mandated package.

Tacking on all types of coverage, including services by people other than doctors, is a form of legislative myopia. In focusing on short-term benefit for a few individuals, the legislators lose sight of the long-term consequences --

greatly increased costs of insurance and further discouragement of employers adding other, more needed benefits for their employees.

It is easy to understand why those seeking a solution to the access problem would turn to the employer community for coverage. Employers already provide coverage for over 130 million Americans. Employers already pay over $110 billion annually for health coverage for employees and their dependents, not including taxes paid toward public health expenditures. In light of these facts, an apparently easy way to expand access is to require those employers not providing coverage to employees to do so. This approach has another great attraction. It is believed that access will be expanded with no direct expenditure of state or federal funds.

As is often the case, however, simple solutions to problems are really not solutions. In this case, it is really an acknowledgement of failure.

Those who support mandated benefits are essentially giving up the effort to control health care costs. Mandated employer provided coverage writes a blank check to the health care providers. Despite all the recent cost containment measures

undertaken by businesses, and government, health care cost increases continue to escalate. It is wishful thinking to assume that the increased demand for health care that would be created by mandated health insurance would somehow reduce health care costs.

Moreover, the cost of mandated insurance coverage would severely impact segments of our economy, especially the small business and retail sectors. Of course, from NJFC's perspective, the most significant impact would be on the food distribution industry. To understand this impact, it is necessary to review the economics and the demographics of our industry.

Food retailers, wholesalers, and manufacturers currently employ approximately 200,000 people in New Jersey. This represents one of the largest segments of the workforce and one of the fastest growing. Since 1980, our industry has created close to one million new jobs nationally.

Last year, American's spent $329 billion in grocery stores. Total food sales, including restaurants, were $413 billion. In other words, as a nation we spent $100 billion less for food than we did for health care. Additionally, Americans

spent only 11.7% of disposable income on food compared to 13.6% in 1980. Again, a marked contrast to the health care industry. There are, of course, many differences between food distribution and health care, but perhaps the most striking difference is in the competitive nature of the respective industries. Food retailing is a highly competitive industry. Health care is not.

Food distributors voluntarily offer a wide variety of benefits in order to attract and retain a productive, dedicated and loyal workforce. In 1987, our industry conducted a comprehensive survey of benefits offered to our employees. Responses were received from companies, both large and small, many of which are located in New Jersey.

The survey showed that almost all respondents (97%) offer health insurance to their full-time workers. These coverages are, on the whole, comprehensive, generous, and expensive. (A new survey is currently being conducted, and the results will be made available to the Commission in the next several months.)

In the food retailing business, approximately two-thirds of our workforce is part-time. This reflects the nature of our business. The typical supermarket is open over 100 hours a

week; many are twenty-four hour operations. Our industry has always attracted large numbers of young people, students, and others interested in part-time work to supplement their own income from another job, or those of their parents or spouses.

The 1987 industry survey shows that 61 percent of these part-timers are under the age of 21. Eighty-nine percent are under 25. The turnover ratio for part-timers is over seventy percent. In other words, two-thirds of these employees are no longer working for the company one year after hire.

Keep in mind that these are generally lower-paying, entry-level positions. An employee earning the new minimum wage of $3.80, and working 20 hours a week for 50 weeks, will earn $3,800 a year. According to the 1987 survey, the average cost of coverage in New Jersey stores, per employee, was over $3200. Thus, the cost of employing a minimum wage part-timer would go up by over 50% if health insurance had to be provided.

The typical supermarket being built today employs over 100 part-timers. The average supermarket, including the older, smaller stores currently being phased out, employs approximately 50 part-timers. Assuming the relatively low

average of $2000 cost for insurance for each of those employees, the average cost per store would be $100,000. For new stores the cost would be over $200,000.

It is well-known that the food distribution industry operates on the tightest of margins -- only one percent of every dollar received is profit. Therefore, in order to absorb $100,000 in increased costs, a store would have to generate increased sales of $10 million. Food prices would go up. Wage rates would be stabilized, if not reduced. Many other employee benefits would be cut. And many jobs would be eliminated. It would no longer be possible for food retailers to hire many of these individuals on the margin of the workforce.

Some have suggested that part-timers receive a proportional contribution from employers toward their health insurance. We believe that this is a totally unworkable idea.

Employers long ago showed their willingness to provide health insurance, as exemplified by the fact that 65% of our population is now covered by employer health care plans. Unfortunately, many of the state legislatures have not been content to leave this encouraging situation alone -- and thus continue to expand.

Some of the states, at last, are beginning to take a look at what is happening. Six states have enacted or are considering laws that require stringent prior evaluation of proposed mandated benefits, from the standpoint of potential costs and resulting benefits. This is one encouraging sign in a generally discouraging situation.

NJFC believes that the Assembly Health Care Policy Commission will play a crucial role in determining the future of our state's health care system. We congratulate you on your strong leadership of this difficult problem, and we pledge to continue to work with you and all other interested parties on these important issues.

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HFMA

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

NEW JERSEY CHAPTER

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PRESIDENT

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FINANCING UNCOMPENSATED CARE IN NEW JERSEY

The Healthcare Financial Management Association (HFMA) is the nation's leading personal membership organization for more than 27,000 professionals concerned with financial management of healthcare providers. HFMA has 72 chapters throughout the United States. The New Jersey Chapter is comprised of more than 800 finance professionals involved in healthcare delivery whose common concern is the financial viability of New Jersey's healthcare providers. Chapter members volunteer their time and the Chapter has no paid staff. During the past several months, three Chapter Committees - Legislative, Reimbursement and Credit and Collections - have jointly studied the uncompensated care issue and the problems created by the Uncompensated Care Trust Fund Act (P.L. 89:1) that is due to expire December 31, 1990.

The results of their study were presented to the Chapter's Board of Directors on May 22, 1990, and this paper describing the Chapter's position on the issues of uncompensated care was adopted. In addition to providing some salient background information concerning the provision of uncompensated care services by New Jersey's acute care hospitals, the paper makes seven specific recommendations directed towards (1) providing such services in a cost-effective manner and (2) financing the provision of such services in a more equitable manner.

BACKGROUND

New Jersey - "A Civilized Nation"

Twelve years ago, New Jersey's legislators made a commitment that all New Jersey residents would have equal access to healthcare delivery, regardless of ability to pay. That 1978 landmark legislation (N.J.S.A. 26:2H--1, commonly re erred to as Chapter 83) has placed our state in a position that is unique in the nation.

116X

In its 1987 study of access to care in the United States. the Robert Wood Johnson Foundation concluded that New Jersey led the nation in providing equal access to healthcare services. That study. conducted by researchers from the University of Illinois and from the University of California at Los Angeles. concluded that *"the poor. minorities and those lacking health insurance have significantly better access to health care in New Jersey than do low income and uninsured persons in the nation as a whole."* Princeton University's internationally renowned health economist. Uwe Reinhardt. often has referred to our state's delivery system as *"healthcare with a soul"* - we do care for our uninsured citizens - and describes New Jersey as *"a civilized nation. not just a place to live."*

As residents. we should take pride in this enlightened social policy. However. fostering equal access has created other problems because the original uncompensated care legislation provided that such costs would be financed by patients who have insurance. Initially. uncompensated care costs were dealt with on a hospital-specific basis. Each hospital's own uncompensated care costs were added to rates paid by that hospital's insured patients. This placed our inner-city hospitals. who have higher uncompensated care burdens. at a competitive disadvantage. Their rates became significantly higher than the rates at neighboring suburban hospitals due to the shifting of the significant costs of care provided to medically indigent patients. In 1986. additional legislation was passed establishing the Uncompensated Care Trust Fund which enabled these costs to be shared statewide through a uniform add-on to each hospital's mark-up factor. In 1987. the Trust Fund became the vehicle for collecting funds from hospitals that had lower levels of uncompensated care and disbursing the funds to hospitals that had higher levels of uncompensated care.

That financing mechanism worked reasonably well while Medicare was picking up its pro-rata share of the statewide uncompensated care costs. However. that situation changed dramatically January 1. 1989 when Medicare terminated its inpatient waiver and reverted to its prior policy of covering only those hospital bad debts incurred in serving Medicare beneficiaries. Medicare ceased contributing its fair share to the total uncompensated care provided to uninsured and unemployed individuals in New Jersey. There appears to be no room in the federal budget for *"healthcare with a soul."* Since Medicare beneficiaries account for nearly 45 percent of hospital inpatients in New

Jersey. a significant amount of uncompensated care costs had to be shifted to other insured patients and self-pay patients. This shift was mandatory under New Jersey's Chapter 83 rate setting system. an all payor system in which hospital revenue bases are controlled in total by the Department of Health and the Hospital Rate Setting Commission. Consequently. the cost shift triggered (1) huge increases in health insurance premiums and complaints from employers who pay those premiums. and (2) increases in the rates charged to self-pay patients that often result in higher uncompensated care amounts when such patients don't pay.

We will briefly discuss these two issues - uncompensated care and the apparent increase in uncompensated care costs - before presenting the HFMA's recommendations for preserving access to health care for all New Jersey residents.

What Causes Uncompensated Care?

In general. there are two principal causes of uncompensated care:

- Patients who are unemployed or marginally employed. but not eligible for Medicaid. and

- Patients who are fully or partly employed. but uninsured.

Patients in the first category frequently are referred to as those *"unable to pay"* and the cost of their care often is written off to charity care when they can establish that they meet the State's charity care guidelines. Patients in the second category at times are termed those *"unwilling to pay"* and the costs of their care often winds up being written off to bad debt. However. in the day-to-day provision of healthcare services. the situation is not always this black and white - there are many shades of gray. Compounding the issue. hospitals are required by law to provide services to all patients regardless of the source of payment and to follow specific and detailed credit and collection procedures.

Why Are Uncompensated Care Costs Increasing?

Uncompensated care costs are estimated to have increased from roughly $233 million in 1983 to $366 million in 1986 and to an estimated $650 million in 1990. Stated another way. such costs appear to have increased from 6.1 percent of hospital revenues in 1986 and to an estimated 10.5 percent in 1990.

However. in our analyses. the primary cause of the cost increases has been the shortfall created when the Medicare program withdrew completely from New Jersey's rate-setting system January 1. 1989. This Medicare shortfall - the difference between what New Jersey's rate-setting system would have paid hospitals and the lesser amount paid under Medicare's Prospective Payment System - must. by law. be absorbed by other payers. In 1989. the Medicare shortfall amounted to an estimated $244 million: 1990 estimates of the Medicare shortfall approximate $300 million.

When uncompensated care costs are adjusted to give effect to the Medicare shortfall. it is clear that uncompensated care costs as a percentage of hospital revenues peaked in 1987. and have been declining since (see Exhibit 1. attached). Put simply. the raw data suggest that uncompensated care costs increased by $62 million in 1988 (from $465 million to $527 million). However. when the $156 million Medicare cost shift is taken into account. the comparable uncompensated care costs dropped to $371 million. As a percentage of hospital revenues. real uncompensated care costs peaked in 1987 at 7.8 percent of revenues. and now account for roughly 5.9 percent of hospital revenues. This is within the range of amounts reported as uncollectible in the Hospital Accounts Receivable Analysis quarterly survey during 1989.

Clearly. as shown on Exhibit 1. the apparent increases in uncompensated care have not been caused by allegedly inadequate hospital credit and collection practices. nor have they anything to do with the functioning of the Uncompensated Care Trust Fund. The apparent increases are primarily attributable to the Medicare shortfall. This is a Medicare funding problem. not a hospital operational problem or a Trust Fund administration problem.

Shifting the Medicare shortfall to other insurance carriers is the primary cause of the increases in health insurance premiums. and these increases have fallen most heavily on New Jersey businesses that provide health insurance coverage to their employees. It is both ironic and unfair that those who

provide coverage (and thus do not add to uncompensated care costs because their employees have health insurance coverage) are forced to shoulder the biggest part of the uncompensated care burden. Conversely, businesses that provide little or no health insurance coverage to their employees are exempt from the uncompensated care burden that their employees may generate.

RECOMMENDATIONS

Broaden the Funding Mechanism

HFMA urges that the funding mechanism for uncompensated care be broadened so that the burden is shared more equitably. Specifically, HFMA recommends that:

1. Taxes on tobacco and alcohol should be increased significantly, and the revenues resulting from these increased taxes be remitted to the Uncompensated Care Trust Fund. Research studies have shown both tobacco and alcohol consumption to cause health problems, and significant amounts of uncompensated care costs are incurred by patients admitted to hospitals' substance abuse programs. A one-third increase in alcohol taxes would produce roughly $50 million.

2. A payroll tax should be imposed on <u>all</u> employers to finance the balance of uncompensated care costs. Conceptually, the tax should function on an "as needed" basis in a manner similar to the unemployment compensation tax (i.e., employers who provide health benefits would receive a credit while those who do not provide health benefits would be fully taxed). A payroll tax of up to $1,500.00 per employee (roughly the annual cost of providing single coverage) could raise roughly $525 million.

HFMA believes that this broader funding mechanism would spread uncompensated care costs across a broader and more appropriate base. In the event that these two taxes produce either an excess or a shortfall compared to actual uncompensated care costs, the existing hospital rate setting system should be used to increase or decrease the total fund.

Our next recommendations are directed at reducing the level of uncompensated care in New Jersey and increasing the Federal government's contribution to health care in New Jersey.

Expand Medicaid Eligibility and Permit Enrollment at Hospital Sites

To reduce the costs of uncompensated care to New Jersey taxpayers. HFMA recommends that:

3. Medicaid eligibility criteria be expanded to the federally allowed maximum. This would increase the number of New Jersey residents who are eligible for Medicaid and reduce the uncompensated care burden financed by New Jersey taxpayers. Since federal government contributes 50 cents of every Medicaid dollar. this would increase the flow of federal funds for healthcare to New Jersey.

4. A waiver to federal. state and local social service laws should be obtained that would permit potential Medicaid recipients to be qualified at hospital sites. This would provide assurance that the Medicaid eligibility determination process is initiated in a timely manner and would relieve hospitals from having to follow up to ensure that the patient or guarantor actually visits the local welfare office to complete the screening process. Conceptually. this plan would be very similar to the program that has operated successfully in New York City for several years.

HFMA believes that such measures will benefit providers. the public and the State. As a state. New Jersey typically has ranked near the bottom in terms of federal dollars returned to the state. Expanding Medicaid eligibility would bring more federal dollars back to New Jersey helping to provide a more equitable "balance of trade" with the federal government.

Our final recommendations are directed at keeping the costs of compliance with the Uncompensated Care Trust Fund regulations in line with the benefits obtained.

Permit More Cost-Effective Compliance Procedures

Compliance with pre-service and post-discharge procedures mandated by sections 9 and 10 of the present Act is proving to be extremely costly and anecdotal evidence to date suggests that the benefits obtained (i.e.. increased cash collections and reduced bad debt write-offs) are minimal. Last year. an HFMA

survey conducted jointly with the New Jersey Hospital Association determined that the estimated annual costs of compliance with Sections 9 and 10 would be roughly $25.5 million statewide. The present Act treats all patient types (e.g., inpatients, same-day surgery patients, clinic patients, referred outpatients and emergency room patients) equally. The present regulations permit a more limited set of post-discharge (i.e., follow-up and collection) procedures to be performed when self-pay or due-from-patient balances are less than $200.00. In all instances, the identical set of pre-service (i.e., registration and insurance verification/financial screening) procedures are mandated.

These requirements are enforced by retrospective audits of bad debt and charity care accounts. In 1988, the mandatory audit compliance rates were increased. In 1989, the audit criteria were tightened. As a result, hospitals are finding that they need to invest in additional staff, space and equipment in order to minimize their exposure to retrospective audit penalties. Unfortunately, as noted earlier, these cost increases do not appear to be producing significant benefits (i.e., increased cash collections). To foster cost-effective compliance with the Uncompensated Care Trust Fund Act and its implementing regulations, HFMA recommends changes to the Act and the regulations whereby:

5. Patients registered in and discharged from the emergency room would be exempted from the pre-service requirements relating to Medicaid referrals and charity care screening.

6. A more limited set of post-discharge procedures would be permitted for patients with due-from-patient or self-pay balances under $500.00.

7. The Uncompensated Care Trust Fund Act would be modified to permit more flexibility in tailoring the credit and collection procedures to each hospital's needs.

Hospitals are required by licensure to provide emergency services. Patients arriving at emergency rooms usually are unprepared to provide the extensive and detailed financial information required by the Act and regulations. In fact, data compiled for one month last year in a Trenton hospital's emergency room showed that fully 40 percent of patients arriving had no identification available. Exempting such patients from the two audit criteria mentioned above would help make it easier to attain the 70 percent compliance rate for

outpatient accounts. Not exempting them would expose the State's inner city hospitals to a Hobson's choice among (1) incurring significant added costs that might not be reimbursed, (2) risking significant retrospective audit penalties for noncompliance, and (3) refusing to serve the medically indigent that the Trust Fund was designed to benefit.

Permitting more limited post-discharge procedures for due-from-patient and self-pay balances under $500.00 would reduce the aggregate costs for compliance, move the largest volumes of accounts through the process more efficiently, and bring third-party intervention to bear sooner. Unfortunately, consumers are less likely to pay bills for healthcare services than they are to pay rent, utility and installment charge bills. After all, failure to pay the rent bill could lead to eviction and failure to pay the installment charge could lead to repossession of the television, VCR or appliance purchased on credit. But medical treatment, once provided, cannot be taken back. In the vast majority of cases, it takes third-party intervention and the threat to an individual's credit rating to get the medical bill paid. Studies indicate that the likelihood of collection diminishes rapidly (see Exhibit 2, attached) as due-from-patient balances age. Thus, moving unresolved due-from-patient balances more quickly to a collection agency should be encouraged, particularly when one considers that such accounts frequently are 60-90 days old before insurance payments or denials are received and due-from-patient balances can be pursued.

If the Uncompensated Care Trust Fund Act permitted flexibility in evaluating the cost-effectiveness of collection procedures performed, rather than mandating that a prescribed series of detailed procedures be performed, the Law's cost-effectiveness would be greatly enhanced, resulting in lower healthcare costs to all who pay for healthcare services.

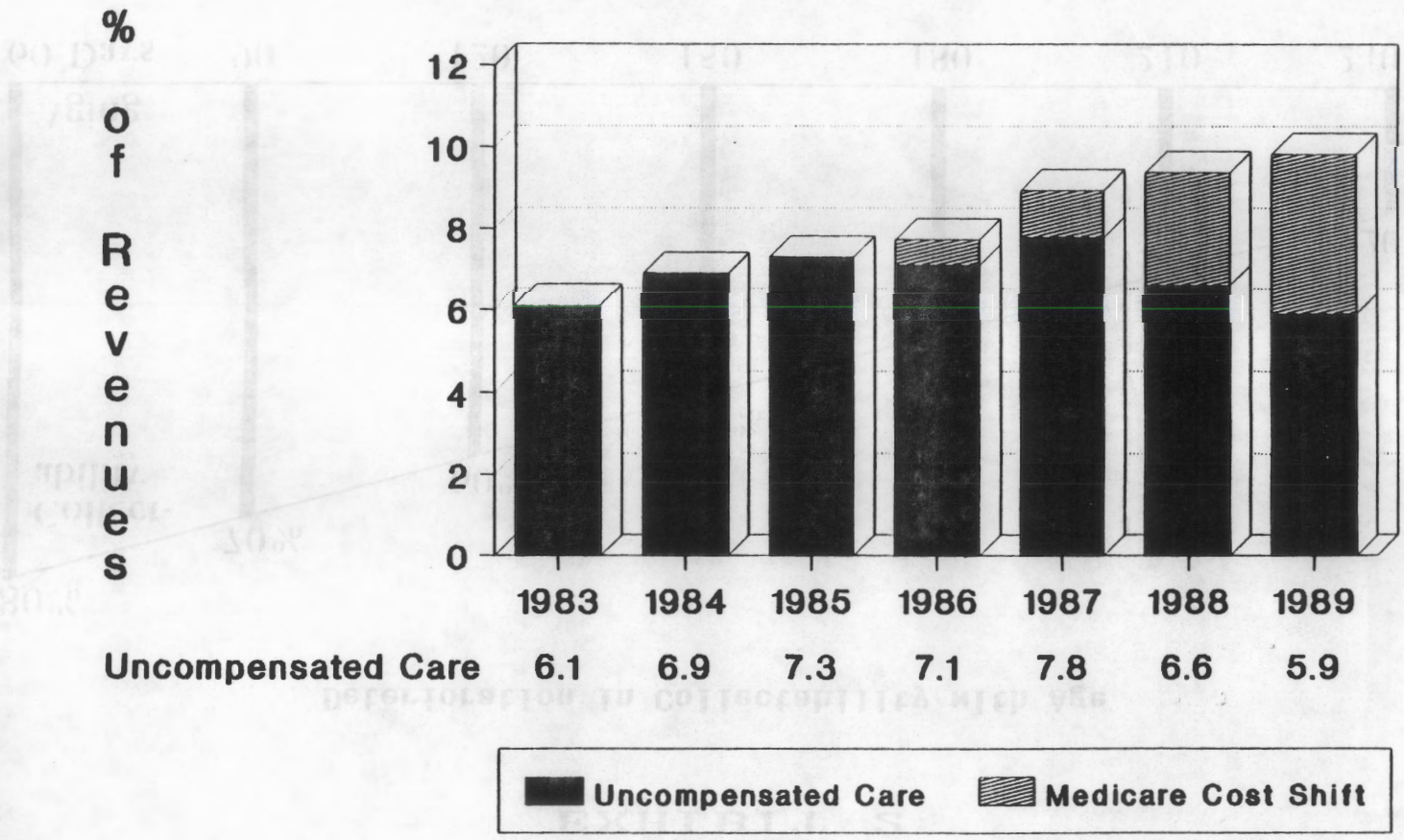
CONCLUSION

HFMA believes that finding solutions to the issue of increasing uncompensated care costs has little to do with expanding the already extensive regulations of hospital credit and collection practices. Rather, the increase in such costs relates primarily to the Medicare program's refusal to contribute its fair share to caring for those who are uninsured and cannot pay, but do not qualify for Medicaid. When uncompensated care costs are adjusted to take the Medicare shortfall into account, these costs as a percentage of hospital revenues peaked

in 1987. have declined since then. and are within the ranges reported in national surveys of hospital accounts receivable.

HFMA believes that implementing the foregoing seven recommendations will: (1) enable New Jersey's hospitals to continue to provide uncompensated care services in a cost-effective manner. (2) help the State to finance the provision of such services in a more equitable manner: and (3) preserve access to care for all New Jersey residents. We would be pleased to answer any questions you may have with respect to the information and recommendations presented herein.

Uncompensated Care Cost Trends, 1983-89
Costs as Percentage of Hospital Revenues



DATA SOURCE: N J Department of Health

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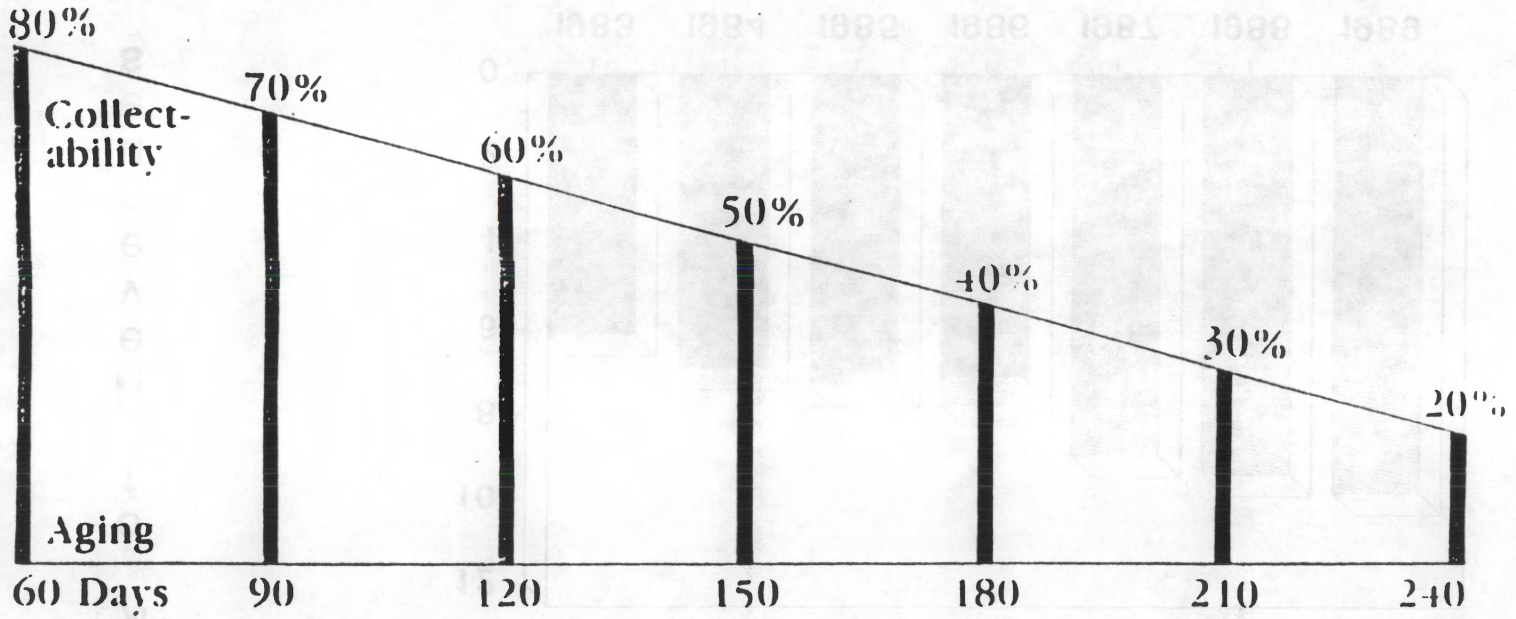
EXHIBIT 2

Deterioration in Collectability with Age



SOURCE: Transworld Systems, Inc., Paramus, NJ

NFIB New Jersey

National Federation of
Independent Business

NFIB/NEW JERSEY

TESTIMONY BEFORE

THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

JULY 18, 1990

Presented by:
Laura Giannotta
Director, NFIB/New Jersey

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The Guardian of
Small Business

137X

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.

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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. & 1b.)

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 (2a. attached). This is working in North Carolina. A program recently enacted in Connecticut (3a. attached) 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 (4a. attached). This too should be studied.

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.

The legislative response to this serious problem 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.

130X

Proposed Insurance Expansion Projects

Below is a description of two proposed components of the Insurance Expansion Project. As you will see, many of the previous decisions of the Working Group are incorporated into these two projects.

1. Dependent Coverage Expansion by Leveraging Existing Coverage

Summary Description

Subsidize the purchase of dependent coverage for employees across the State who currently have individual-only coverage. This program would benefit families, primarily women and children, in which the employer of a wage earner pays for individual-only coverage and offers dependent coverage only as an option at the employee's expense. As envisioned, employees' income would be a factor in determining the amount of the subsidy.

Advantages

This program has two important advantages over other strategies considered. First, the per person cost to cover dependents is much less than that of selling new policies to uninsured employees. It is estimated that the average cost of dependent coverage is roughly $600 per year. Assuming an average family size of four, three people could be covered for $200 each. In comparison, the cost of individual coverage is roughly $1500 and the cost of family coverage is roughly $2100. As a result, this program would insure the most people for a given amount of money.

Second, this program primarily targets women and children and thus has special potential to directly reduce the number of uninsured maternity-related admissions -- admissions which make up 35 percent of all uninsured admissions and account for 19 percent of the cost of all uninsured admissions.

Background

According to the Current Population Survey, 32 percent of New Jersey's 223,000 uninsured children under 18 (or 71,000 children) live in a family with at least one insured employed parent. These children as well as uninsured spouses would benefit from the program. In addition, some of the 85,000 uninsured New Jerseyans who are between 18 and 25 and are living in a family with at least one insured employed parent might benefit from the program, depending on how a policy was written.

According to the Eagleton survey of NJ's small businesses, we know the following about how small businesses treat dependent coverage:

- 60 percent of NJ's 150,000 small businesses (ie, 90,000 small businesses) offer insurance to their employees.
- Of these 90,000 small businesses who offer insurance to their employees, 83 percent (ie, 75,000 businesses) offer dependent coverage.
- In these 75,000 small businesses in which dependent coverage is available, no employees opt for the additional coverage in 7 percent of the businesses (ie, 5,250 businesses) and only some employees opt for the coverage in another 31 percent of the businesses (ie, 23,250 businesses).

2. **Expansion of Health Coverage Among Small Employers by Reinsurance Mechanism**

Summary Description

Establish a three-year pilot program in Middlesex and Passaic counties in which a reinsurance mechanism is negotiated with insurers and HMOs for individual and family policies sold to small employers who previously did not offer insurance. Policies eligible for reinsurance would have to be pre-approved as meeting the Program's guidelines.

As envisioned, the Uncompensated Care Trust Fund would "reinsure" the insuror for hospital admissions covered under the program for charges in excess of a specified dollar amount, for example $10,000. For those cases in which a patient with "pilot" coverage had charges in excess of $10,000, the hospital would then bill the insurer for the $10,000 and write-off the amount over $10,000 to the Trust Fund under a special exception to existing credit and collection rules.

Advantages

Reinsurance has the advantage of facilitating coverage in two distinct ways. First, and perhaps most critically, reinsurance would serve to make the small employer population a more attractive market to insurance companies and HMOs because of the limitation on their exposure to risk.. This directly addresses one of the key reasons given for the lack of insurance among many small businesses, ie, that insurers and, in particular HMOs, tend to view small groups as being more risky than large groups -- a phenomenon which is evidenced by the fact that some insurance companies and HMOs will not sell policies to small businesses.

Second, the insurer's limited risk would also have a secondary benefit of reducing the premium, thus making insurance more affordable to small employers and their employees. A $10,000 limit on the insurer's liability would result in an estimated 5 percent to 12.5 percent reduction in the premium.

An increase in the State's uncompensated care amount is not anticipated to result from the special write-off rule because, had the hospitalized patient not had <u>any</u> insurance, his/her bill in excess of $10,000 would likely have become a bad debt anyway. Furthermore, a study of uninsured admissions in New Jersey indicates that few bills are that large -- 98 percent are $10,000 or less and bills $10,000 or less account for 89 percent of the total cost of uninsured admissions.

Background

According to the Current Population Survey, 42 percent of NJ's uninsured are employed adults (ie, 356,000 persons) and at least 66 percent of all NJ's uninsured are either employed adults or in a family with an employed adult (ie, 556,000 persons). National studies indicate that many uninsured employed persons are employed by small businesses.

According to the Eagleton survey, 40 percent of NJ's 150,000 small businesses do not offer health coverage to their employees (ie, 60,000 businesses).

Florida House of Representatives - 1989

HB 325

By Representatives Grindle, Deutsch, Locke, Gordon, Dantzler, Arnall, C. F. Jones, King, Juri, Irvine, Gutman, Kelly, Margrett, 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.

18

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1990 SESSION

LD2759137

SENATE BILL NO. 486
AMENDMENT IN THE NATURE OF A SUBSTITUTE
(Proposed by the Senate Committee on Education and Health
on February 1, 1990)
(Patron Prior to Substitute--Senator Walker)

A BILL to amend and reenact § 38.2-4214 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 4, consisting of sections numbered 38.2-3425 through 38.2-3430, relating to accident and sickness insurance.

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4214 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 4, consisting of sections numbered 38.2-3425 through 38.2-3430, as follows:

Article 4.

Limited Mandated Benefit Accident and Sickness Insurance Policies and Subscription Contracts.

§ 38.2-3425. Issuance of limited mandated benefit accident and sickness insurance policies and subscription contracts permitted.--A. Insurers and health services plans may issue limited mandated benefit accident and sickness insurance policies or subscription contracts meeting the criteria set forth in this article.

B. For purposes of this article, "limited mandated benefit accident and sickness insurance policy or subscription contract" means a policy or subscription contract which the insurer or health services plan may choose to offer to individuals, families, or groups of less than fifty members formed for purposes other than obtaining insurance coverage, and which meets the following criteria:

1. The individual, family, or group obtaining coverage under the policy or subscription contract shall have been without accident and sickness insurance coverage for all of the twelve-month period immediately preceding the effective date of the limited mandated benefit accident and sickness insurance policy or subscription contract, provided that for groups in existence for less than twelve months, the group shall have been without accident and sickness insurance coverage since inception of the group.

2. The insurer or health services plan shall include the following managed care provisions to control costs:

a. An exclusion for services that are not medically necessary; and

b. A procedure for preauthorization by the insurer or health services plan, or its designees, of any medical service the cost of which is anticipated to exceed a minimum threshold amount, except for services necessary to treat a medical emergency;

3. The insurer or health services plan may include the following managed care provisions to control costs:

a. A preferred panel of providers who have entered into written agreements with the insurer or health services plan to provide services at specified levels of reimbursement. Any such written agreement between a provider and an insurer or health services plan shall contain a provision under which the parties agree that the insured individual or covered member will have no obligation to make payment for any medical service rendered by the provider that is determined not to be medically necessary;

b. A provision under which any insured individual or covered member who obtains medical services from a nonpreferred provider shall receive reimbursement only in the amount that would have been received had services been rendered by a preferred provider, less twenty percent;

c. In the event that geographic circumstances preclude the creation of a preferred panel of providers as set forth in subdivisions a and b above, the Commission may approve a limited mandated benefit accident and sickness insurance policy or subscription contract without the preferred panel; and

d. Provisions requiring a second surgical opinion and a procedure for utilization review

134X

by the insurer or health services plan or its designees.

Nothing herein shall be construed to prohibit an insurer or health services plan from including in its policy or subscription contract additional managed care and cost control provisions which, subject to the approval of the Commission, have the potential to control costs in a manner which does not result in inequitable treatment of insureds or subscribers.

4. The policy or subscription contract shall provide basic levels of primary, preventive, and hospital care for covered individuals, including, but not limited to, the following:

a. A minimum of thirty days of inpatient hospitalization coverage per policy year;

b. Prenatal care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy, and one office visit per week during the ninth month and until term. Coverage for each such visit shall include necessary and appropriate screening, including history, physical examination, and such laboratory and diagnostic procedures as may be deemed appropriate by the physician based upon recognized medical criteria for the risk group of which the patient is a member. Coverage for each office visit shall also include such prenatal counseling as the physician deems appropriate;

c. Obstetrical care, including physicians' services, delivery room, and other medically necessary hospital services; and

d. Well-baby and well-child care, including periodic review of a child's physical and emotional status by a physician or under a physician's supervision. Such review shall include, but not be limited to, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards. Such reviews shall be covered when performed at approximately the following age intervals: (i) birth, (ii) two months, (iii) four months, (iv) six months, (v) nine months, (vi) twelve months, (vii) fifteen months, (viii) eighteen months, (ix) two years, (x) three years, (xi) four years, (xii) five years, and (xiii) six years.

e. For other covered individuals, a basic level of primary and preventive care, including but not limited to, two physician office visits per calendar year.

§ 38.2-3426. Exemption of limited mandated benefit accident and sickness policies and subscription contracts from certain mandates.—Any policy or subscription contract issued pursuant to this article may be issued without the requirements of §§ 38.2-3408, 38.2-3410, 38.2-3412, 38.2-3413, 38.2-3417, or 38.2-4221.

§ 38.2-3427. Disclosure requirements for limited mandated benefit accident and sickness insurance policies and subscription contracts.—A. Before any insurer or health services plan issues a limited mandated benefit accident and sickness insurance policy or subscription contract, it shall obtain from the prospective policyholder a signed written statement in which the prospective policyholder (i) certifies as to eligibility for coverage under the limited mandated benefit accident and sickness insurance policy or subscription contract, (ii) acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the insurance policy or subscription contract, (iii) acknowledges that if misrepresentations are made regarding eligibility for coverage under a limited mandated benefit accident and sickness policy or subscription contract that the person making such misrepresentations shall be guilty of a Class 1 misdemeanor and shall forfeit coverage provided by the limited mandated benefit accident and sickness policy or subscription contract, and (iv) acknowledges that the prospective policyholder had, at the time of application for this insurance policy or subscription contract, been offered the opportunity to purchase coverage including all applicable mandated benefits and that the prospective policyholder had rejected such coverage. A copy of such written statement shall be provided to the prospective policyholder no later than at the time of policy delivery, and the original of such written statement shall be retained in the files of the insurer or health services plan for the longer of (i) the period of time that the policy or subscription contract remains in effect or (ii) five years.

B. Upon coverage under a limited mandated benefit accident and sickness insurance

policy or subscription contract taking effect for any individual, family, or group member, the insurer or health services plan shall provide such individual, family, or member with a written disclosure statement containing at least the following:

1. An explanation of those mandated benefits and provides not covered by the policy or subscription contract;

2. An explanation of the managed care and cost control features of the policy or subscription contract, along with all appropriate mailing addresses and telephone numbers to be utilized by insureds in seeking information or authorization; and

3. An explanation of the primary and preventive care features of the policy or subscription contract.

Such disclosure statement shall be presented in clear and understandable form and format and shall be separate from the insurance policy or certificate or evidence of coverage provided to such individual, member, or dependent.

C. Any material statement made by an applicant for coverage under a limited mandated benefit accident and sickness insurance policy or subscription contract which falsely certifies as to the applicant's eligibility for coverage pursuant to § 38.2-3425 B shall be deemed a Class 1 misdemeanor and shall serve as the basis for termination of coverage under the policy or subscription contract.

D. All marketing communications intended to be utilized in the marketing of a limited mandated benefit accident and sickness product in this Commonwealth shall be submitted for review by the Commission prior to use and shall contain the disclosures stated in subsection B above.

§ 38.2-3426. Forms and rates to be filed with and approved by the Commission.—A. All limited mandated benefit accident and sickness policy forms, including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be submitted to the Commission for approval in the same manner as required by § 38.2-316.

B. No limited mandated benefit accident and sickness insurance policy or subscription contract may be issued or issued for delivery in this Commonwealth unless the rates therefor have been filed with and approved by the Commission. The rates shall be supported by an actuarial memorandum meeting the requirements of the Commission's regulations governing the filing and approval of individual and certain group accident and sickness insurance rates as presently in effect or as may hereafter be amended. No rate shall be considered reasonable nor shall it be approved unless (i) it is based upon a pool or community rating formula and (ii) it is likely to produce a loss ratio, as certified by a qualified actuary, of no less than seventy-five percent for group contracts and sixty percent for individual contracts.

§ 38.2-3429. Recordkeeping and reporting requirement.—Each insurer or health services plan issuing limited mandated benefit accident and sickness policies or subscription contracts in this Commonwealth shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and such other information as may be required by the Commission. Each insurer or health services plan providing such policies or plans shall furnish an annual report to the Commission. The report shall be in a form prescribed by the Commission and shall contain such information as the Commission may require to analyze the success of insurance coverage issued pursuant to this article.

§ 38.2-3430. Sunset provisions.—The provisions of this act shall expire on July 1, 1994.

§ 38.2-4214. Application of certain provisions of law.—No provisio[illegible] of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3409, 38.2-3411 through 38.2-3419, *38.2-3425 through 38.2-3429,*

136X

States Tailor Benefit Laws to the Needs of Small Businesses

4/16/90

By Albert B. Crenshaw
Washington Post Staff Writer

In departure from the typical pattern of state health insurance regulation, Virginia has enacted a new law aimed at making basic coverage available to small businesses that have until now been unwilling or unable to afford it.

Under a measure signed by Gov. L. Douglas Wilder last week, insurers will be allowed to offer policies that do not have many of the features that state law requires in normal group health insurance policies. These so-called mandated benefits include such things as mental health, alcohol and drug abuse treatment and mammography screening.

Virginia requires 24 specific benefits. In some states the total is as high as 38. And the number grows each year. So far, according to the Health Insurance Association of America (HIAA), an insurance trade group, there are 816 different mandates among the 50 states.

Most of these required benefits are fairly straightforward, but some get fairly exotic. Minnesota, for example, mandates coverage of hair transplants, and there are periodic attempts in various state legislatures to include acupuncture.

Insurers have long argued that requiring coverage of all these different items drives up the cost of health insurance and discourages small employers from offering it.

Under the Virginia law—modeled after one enacted in Oregon last year—employers with 49 or fewer workers and that have not offered health insurance in the past 12 months may buy insurance that does not include the state's mandated coverage.

The law takes effect July 1 and is already at ing attention.

Blue Cross and Blue Shield of Virginia are r ing a package they expect to be priced at about thirds of what a normal policy would cost. Ther 880,000 people in Virginia who do not have h insurance, "and we believe this would appe about 350,000 of those," a spokesman said.

If things work out as planned, the policy wil about $100 per worker per year, officials said cover hospitalization, accidental injury, mate surgery, some home health care and other be and, according to product manager Donna D will strongly emphasize preventive medicine.

The policy will cover 100 percent of the c many preventive items after a $10 copayment t employee, she said. "We looked at the target m

See BENEFITS, page 6

New Benefit Laws Are Emerging

BENEFITS, from page 5

and tried to design benefits to meet that population," she said.

She conceded that the new plan "is not comprehensive," but said that "our concern was to get the most needed levels of care."

In addition to Oregon and Virginia, Washington has also enacted a similar measure, and according to the HIAA, legislatures in a half dozen other states, including Maryland, have been looking at the idea. "It's something a state can do without costing itself a lot of money," said Woody Eno of HIAA.

He noted that employers who have bitten the bullet and are already providing health insurance cannot benefit under the Virginia plan, but he said the political reality is that providers favored by the mandates were able to protect their interests.

Eno said Connecticut is considering a measure that would allow small businesses to buy insurance under policies that would pay providers the same rate that the federal Medicaid program does. If this works, it could save money because Medicaid sets rates that are usually lower than those normally charged by providers.

The long-term impact of either the Connecticut or Virginia approach is not clear, but Eno said he feels "the proposals will go a long way toward holding the line" on rising medical insurance costs. ■

137X

Health Insurance

2A

GENERAL ASSEMBLY OF NORTH CAROLINA
1987 SESSION
RATIFIED BILL

CHAPTER 765
SENATE BILL 759

AN ACT TO AUTHORIZE THE FORMATION OF MULTIPLE EMPLOYER TRUSTS TO PROVIDE HEALTH INSURANCE.

The General Assembly of North Carolina enacts:

Section 1. The General Statutes of North Carolina are amended by adding a new Chapter to read:

"Chapter 58A.

"North Carolina Health Insurance Trust Commission.

"**§ 58A-1. Short title.**--This Chapter shall be known as and may be cited as the North Carolina Health Insurance Trust Commission Act.

"**§ 58A-2. Legislative intent.**--The General Assembly finds that there is insufficient group health insurance coverage available to employees of many small businesses in North Carolina, that uninsured employees of these small businesses represent a significant portion of the uncompensated costs of health care providers, and that uninsured individuals have impaired access to health care services and corresponding lower health status. It is the intent of the General Assembly that a Commission, to be known as the 'North Carolina Health Insurance Trust Commission', be organized for the purpose of assisting in making economic health insurance available to individuals employed by small businesses, and their dependents, who are presently uninsured.

"**§ 58A-3. Commission authorized, duties, program eligibility requirements, powers.**--(a) There is created the 'North Carolina Health Insurance Trust Commission', hereafter referred to as the 'Commission'.

(b) The Commission shall:

(1) Facilitate the provision of group health insurance for employers with 25 or fewer employees, their employees, and their employees' families;

(2) Arrange for the development of a health insurance benefit plan to provide coverage for primary and ambulatory health care and inpatient hospital care, including the development of pilot programs;

(3) Establish administrative and accounting procedures for the operation of the Commission;

(4) Establish employer and employee eligibility criteria for participation in the program;

(5) Establish participation criteria governing eligibility of authorized insurers, authorized health maintenance organizations, and others, operating in accordance with the General Statutes, to participate in the program;

(6) Establish procedures under which applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the Commission;

(7) Contract with authorized insurers to provide services to the Commission;

(8) Develop and implement a plan to publicize the Commission, the eligibility requirements for the program, the procedures for enrollment in the program, and to maintain public awareness of the Commission and the program;

(9) Secure staff necessary to properly administer the Commission. Staff costs shall be funded from grant funds, State and local matching funds, and other sources. The Commission shall be located in the Department of Insurance and shall be given necessary administrative support by the Department of Insurance;

(10) Enter into contracts necessary to carry out the provisions of this Chapter; and

(11) Provide an annual report to the General Assembly each year beginning not later that March 1, 1989.

(c) The Commission shall set business and employee eligibility standards which shall define limits on employers and employees eligible for participation in the program. Small businesses eligible for participation shall have 25 or fewer full-time employees. Employer eligibility standards shall include a provision that the employer must attest to not having offered or provided any other health insurance benefits in the two-year period prior to the employer's date of application to the program. The Commission shall make all necessary provisions to prevent the payment of or reimbursement for any claim or expense which may be covered under a separate health insurance or health care services plan under which an individual who participates in the program may be covered.

(d) The Commission shall have all powers necessary or convenient to carry out the purposes and provisions of this Chapter, including, but not limited to, the power to receive and accept grants, loans, and advances of funds from any public or private agency, for, or in aid of, the purpose of this act, and to receive and accept contributions, from any source, of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this Chapter.

"**§ 58A-4. Commission composition; appointment; terms; reimbursement; and liability.**--(a) The Commission shall consist of ten members:

(1) One member shall represent small businesses whose employees are eligible to participate in the program established by the Commission;

(2) One member shall be a representative of an acute care hospital providing services to the program;

(3) One member shall be a representative of a domestic health care insurer licensed pursuant to Chapter 57 of the General Statutes;

(4) One member shall be a representative of a domestic health care insurer licensed pursuant to Chapter 58 of the General Statutes;

(5) One member shall be the Secretary of Human Resources or his designee;

(6) One member shall be the Commissioner of Insurance or his designee;

(7) One member shall be a representative of the North Carolina business community whose company provides health insurance to its employees;

(7a) One member shall be a representative of the public;

(8) One member shall be a physician licensed to practice medicine in North Carolina and providing services to the program; and

139X

(9) One member shall be a representative of the public, be familiar with health insurance issues, and be an advocate of low and moderate income employees.

(b) The Commission shall be appointed by the General Assembly, in accordance with G.S. 120-121, in the following manner:

(1) One representative of small business employers eligible to participate in the program shall be appointed for an initial term of three years;

(1a) One person who shall be a representative of the public shall be apointed for an initial term of one year;

(2) One domestic health care insurer licensed pursuant to Chapter 57 of the General Statutes shall be appointed for an initial term of two years; and

(3) One physician licensed to practice medicine in North Carolina shall be appointed for an initial term of one year

upon the recommendation of the Speaker of the House of Representatives; and

(1) One representative of an acute care hospital shall be appointed for an initial term of three years;

(2) One domestic health care insurer licensed pursuant to Chapter 58 of the General Statutes shall be appointed for an initial term of two years;

(3) One representative of the business community whose company provides health insurance to its employees shall be appointed for an initial term of two years; and

(4) One representative who shall represent the public and who is familiar with health insurance issues to serve as an advocate for low and moderate income employees shall be appointed for an initial term of one year

upon the recommendation of the President of the Senate.

Initial one year terms shall expire June 30, 1988, initial two year terms shall expire June 30, 1989, and initial three year terms shall expire June 30, 1990.

After the initial terms expire, terms shall be for three years. Vacancies shall be filled in accordance with G.S. 120-122.

(c) Commission members may be reimbursed by the Commission for actual and necessary expenses incurred by them as members, in accordance with G.S. 138-5, but may not otherwise be compensated for their services.

(d) There shall be no liability on the part of, and no cause of action of any nature shall arise against any member of the Commission, its employees or agents for any action taken in good faith and without malice, in performance of their powers and duties under this Chapter.

"**§ 58A-5. Licensing, fiscal control.**--(a) The Commission is not an insurer. The Department of Insurance may require that any marketing representatives used and compensated by the Commission be licensed as representatives of insurance companies, health maintenance organizations, or other insurance providers, with whom the Commission may contract.

(b) The Commissioners shall have complete fiscal control over the Commission and shall be responsible for all Commission operations."

Sec. 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(55) The North Carolina Health Insurance Trust Commission, as established by G.S. 58A-3."

Sec. 3. This act is effective upon ratification.

In the General Assembly read three times and ratified this the 11th day of August, 1987.

ROBERT B. JORDAN III

Robert B. Jordan III
President of the Senate

LISTON B. RAMSEY

Liston B. Ramsey
Speaker of the House of Representatives

141X

3A

GOVERNOR'S OFFICE

For Further Information:

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FOR RELEASE

4 P.M. THURSDAY
MAY 17, 1990

GOVERNOR O'NEILL SIGNS LEGISLATION CONCERNING HEALTH INSURANCE

Governor Bill O'Neill today signed legislation to make health insurance more accessible to uninsured residents in Connecticut.

The legislation, developed by a Blue Ribbon Commission on Insurance, calls for more affordable insurance for employers with 25 or fewer employees, and for changes in underwriting and rating policies for health insurance companies in the small employer market.

The legislation initiates a program to expand programs for needy residents, targeting pregnant women within certain income guidelines, chonically disabled adults, and medicaid clients going back into the workforce.

"This legislation represents a major step forward for Connecticut," Governor O'Neill said. "The proposal had the backing of consumer groups, the insurance industry, and other interested parties and was the result of extensive studies and discussion during the past year.

"With this legislation, Connecticut moves into the forefront of efforts to access to health care for its uninsured residents," Governor O'Neill said.

The bill was among the more than 30 bills signed late Thursday by Governor O'Neill. A listing of the other bills will be provided Friday.

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142 X

Summary of Senate Bill 342

An Act Concerning the Recommendation of the Blue Ribbon Commission on State Health Insurance

I. Provisions relating to insurers' role in improving coverage for the uninsured.

(A) Provides for the creation of a more affordable insurance policy for small employers (no more than 25 full time employees) who have not insured their employees for at least two years. The "special health care plan" could be purchased for up to three years, and would include coverage for all mandated benefits. Low-income employees will be exempt from balance billing by providers. A similar product will be created for purchase by individuals.

(B) Underwriting restrictions applicable to all health insurance, including special health care plans covering small employers:

(1) Requires that time insured under a previous group plan be taken into account in applying an exclusion from coverage under the plan of the new employer for a pre-existing condition.

(2) Requires that such plans be renewable at the option of the policyholder, unless, for example, the policyholder fails to pay premiums or fails to comply with the requirements of the plan.

(3) Prohibits the exclusion of any eligible employee or dependent from the group based solely on the condition of their health.

(C) Rating restrictions on both an annual and an overall basis are placed on policies covering small employers.

(D) All small employers would be guaranteed the right to purchase a group plan of benefits without regard to the health condition of their employees or dependents.

(E) Provisions relating to reinsurance for high-risk individuals within the small group market.

1. Establishes the Connecticut Small Employer Health Reinsurance Pool and requires participation by all carriers.

2. Provides that, subject to certain limitations, any carrier may reinsure with the pool coverage of any eligible employee of a small employer, or any dependent of such employee.

3. Specifies that when coverage is reinsured with the pool, the premium charged the employer can be no more than the reinsurance charge established by the pool.

4. Provides that pool losses will be assessed to participating carriers, first on the basis of their premiums from policies covering small employers; if additional assessments are required after 5% of small employer premiums are collected, such assessments will be made on the basis of the carriers' total health insurance premiums (other than small employer premiums).

II. Medicaid Provisions

(A) Expands Medicaid coverage to include certain children from families with incomes below 100% of the federal poverty level.

(B) Authorizes the Commissioner of Income Maintenance to pay the employee's share of health insurance premium under a group policy for employees who would otherwise be eligible for medical assistance, and to pay premiums for COBRA continuation coverage for chronically ill and disabled persons who are no longer employed and would otherwise be eligible for medical assistance.

(C) Authorizes the Commissioner of Human Resources to contract with an insurer to provide coverage for pregnant women not eligible for medical assistance and whose families have incomes under 200% of the federal poverty level.

(D) Authorizes the Commissioner of Health Services to establish grants to health care providers to serve the uninsured based on a sliding scale fee.

(E) Allows for the expansion of the availability of the "Katie Beckett" waiver for disabled children to the federal maximum.

(F) Requires the Commissioner on Hospitals and Health Care to develop a plan to lower the cost shift from Medicare to other payors and to improve its hospital data in specific areas. A report to the Public health Committee is required by March 1, 1991.

III. Establishes a Health Care Access Commission to study experience under programs established under this Act, and to periodically report to the General Assembly on its findings.

IV. Requires the Insurance and Public Health Committees to study the effectiveness of the bill's provisions relating to the "Blue Ribbon Policy." This study is to commence on or after July 1, 1993 and result in a report to the General Assembly by February 1, 1994.

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145X

STATE OF CONNECTICUT

Insurance
TO ~~Judiciary~~
4-25-90
Adopted
Voice
4-25-90

AMENDMENT

passes Senate
31-4
4/26/90
repassed w/
31, non changes
as Senate "B"

LCO No. 3490

General Assembly

February Session, A.D., 1990

Offered by SEN. MATTHEWS, 9th DIST.

To Subst. Senate Bill No. 342 File No. 577 Calendar No. 0367

Entitled "AN ACT CONCERNING THE RECOMMENDATIONS OF THE BLUE RIBBON COMMISSION ON STATE HEALTH INSURANCE."

Strike everything after the enacting clause and insert the following in lieu thereof:

Section 1. (NEW) The general assembly declares that it shall be the goal of the state to assure the availability of appropriate health care to all Connecticut residents, regardless of their ability to pay. In achieving this goal, the state shall work to create the means to assure access to a single standard of care for all residents of Connecticut, on an equitable financing basis and with effective cost controls. In meeting the objective of such access, the state shall ensure that mechanisms are adopted to assure that care is provided in a cost effective and efficient manner.

Sec. 2. (a) There is established a health care access commission, within the legislative department, which shall be comprised of: The commissioners of health services, insurance, income maintenance and human resources, the chairman of the commission on hospitals and health care, three members appointed by the president pro tempore of the senate, ne of whom shall be a member of the joint standing committee of the general assembly having cognizance of matters relating to public health, one of whom shall represent community health centers and one of whom

146X

shall represent mental health services; two members appointed by the majority leader of the senate of whom shall represent commercial insurance companies and one of whom shall represent the disabled; three members appointed by the minority leader of the senate, one of whom shall be a member of the joint standing committee of the general assembly having cognizance of matters relating to appropriations and the budgets of state agencies, one of whom shall represent Blue Cross and Blue Shield of Connecticut, Inc., one of whom shall represent small business; three members appointed by the speaker of the house of representatives, one of whom shall be a member of the joint standing committee of the general assembly having cognizance of matters relating to human services, one of whom shall represent consumers and one of whom shall represent labor; two members appointed by the majority leader of the house of representatives one of whom shall represent large business and one of whom shall represent children; three members appointed by the minority leader of the house of representatives, one of whom shall be a member of the joint standing committee of the general assembly having cognizance of matters relating to insurance and real estate, one of whom shall represent hospitals and one of whom shall be a pediatric primary care physician. All members of the commission may be represented by designees.

(b) The commission shall develop the design, administrative, actuarial and financing details of program initiatives necessary to attain the goal described in section 1 of this act. The commission shall study the experience of the state under the programs and policies developed pursuant to this act and shall make an interim report to the general assembly on its findings by January 15, 1991, and a final report on such findings by February 1, 1992. The commission shall make recommendations to the general assembly on any legislation necessary to further the attainment of the goal described in section 1 of this act.

(c) The commission may request from all state agencies such information and assistance as it may require.

(d) The commission may accept any gifts, donations or bequests for any of the purposes of this section and for the achievement of the goal described in section 1 of this act.

Sec. 3. (NEW) On and after January 1, 1991, the commissioner of income maintenance may provide, in accordance with federal law and regulations and within available appropriations, medical assistance under chapter 302 of the general statutes to (1) children over five and under nine years of age whose families have an income below one hundred per cent of the federal poverty level and (2) elderly and disabled persons who would be eligible to receive supplemental security income benefits except for income and who have incomes below one hundred per cent of the federal poverty level.

Sec. 4. Section 17-134u of the general statutes is repealed and the following is substituted in lieu thereof:

(a) The commissioner of income maintenance shall provide, in accordance with federal law and regulations, medical assistance under this chapter to needy pregnant women and children up to one year of age whose families have an income up to one hundred eighty-five per cent of the federal poverty level.

(b) THE COMMISSIONER SHALL IMPLEMENT PRESUMPTIVE ELIGIBILITY FOR APPROPRIATE APPLICANTS FOR ASSISTANCE UNDER THIS CHAPTER WITH AN EMPHASIS ON PREGNANT WOMEN. SUCH PRESUMPTIVE ELIGIBILITY DETERMINATIONS SHALL BE IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS. THE COMMISSIONER SHALL PROVIDE SUCH PRESUMPTIVE ELIGIBILITY DETERMINATIONS ON A PILOT BASIS, IN ONE DISTRICT OFFICE, BEGINNING JUNE 1, 1991, AND SHALL PROVIDE THEM STATEWIDE EFFECTIVE SEPTEMBER 1, 1991.

Sec. 5. (a) The commissioner of income maintenance shall amend the state's model 2176 Medicaid waiver to allow one hundred twenty-five disabled persons to participate under the waiver.

(b) The commissioner of income maintenance may study the feasibility of and costs associated with providing medical assistance coverage under chapter 302 of the general statutes for outpatient substance abuse treatment services. The commissioner shall report her findings and recommendations to the joint standing committees of the general assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies by January 1, 1991.

Sec. 6. (NEW) (a) The commissioner of income maintenance may continue, within available appropriations, to provide medical assistance under chapter 302 of the general statutes to employed persons who have conditions which prevent them from obtaining health insurance under an employer's group health insurance plan and who would otherwise be eligible for such medical assistance.

(b) The commissioner may pay under the medical assistance program, within available appropriations, the employee's share of health insurance under an employer's group health insurance plan for employees who would otherwise be eligible for medical assistance.

(c) The commissioner may pay under the medical assistance program, within available appropriations, the premiums for continued health insurance coverage under an employer's group health insurance plan, pursuant to the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, for chronically ill and disabled persons who are no longer employed and would otherwise be eligible for medical assistance.

Sec. 7. (NEW) (a) The commissioner of health services may contract with an insurer, within available appropriations, to provide a subsidized nongroup health insurance product for pregnant women who are not eligible for medical assistance under chapter 302 of the general statutes and have incomes under two hundred fifty per cent of the federal poverty level and for children under eighteen years of age who are not eligible for such medical assistance and whose families have incomes under two hundred per cent of the federal poverty level. The product shall

be available to such pregnant women and children (1) for whom employer-based insurance is not available or (2) who have employer-based insurance (A) to cover the cost of the premiums, copayments and deductibles of the employer-based plan provided the cost of the employer-based plan is less than the nongroup product and (B) to provide coverage for benefits not covered by the employer-based plan which are covered under the subsidized nongroup product. The contract shall include a sliding scale based on income for premiums, deductibles and coinsurance and shall provide for the use of mechanisms to control costs.

(b) The contract shall include coverage for: (1) Physician visits for diagnosis and treatment; (2) well baby care, immunizations and child health supervision; (3) prenatal and postnatal care; (4) labor and delivery; (5) laboratory and diagnostic tests; (6) outpatient hospital care; (7) prescription drugs; (8) physical therapy; (9) mental health and substance abuse visits, up to fifty visits per year with a cost sharing of fifty per cent and a maximum reimbursement of forty dollars per visit and (10) inpatient care, including mental health and substance abuse treatment, subject to eighty per cent coinsurance on the first two thousand five hundred dollars of expenses.

(c) The commissioner shall establish an outreach program to ensure that eligible persons are aware of the health insurance available pursuant to this section.

(d) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, for purposes of this section.

Sec. 8. (NEW) (a) The commissioner of human resources, after consultation with the commissioner of health services, may contract with an insurer, within available appropriations, to provide a subsidized nongroup health insurance product for disabled persons who would be eligible to receive supplemental security income benefits except for income and who have incomes above the eligibility limit for medical assistance under chapter 302 of the general statutes and under two hundred per cent of the

federal poverty level. The contract shall include a sliding fee schedule based on income for premiums and shall provide for the setting of premiums at a level to cover twenty per cent of program costs. The contract shall provide for the use of mechanisms to control costs.

(b) The contract shall provide the same benefits as are provided under contracts issued pursuant to chapter 692 of the general statutes except mental and nervous disorders shall be covered in accordance with section 38-174d of the general statutes, as amended by public act 89-86.

(c) The commissioner shall establish an outreach program to ensure that eligible persons are aware of the health insurance available pursuant to this section.

(d) The commissioner may adopt regulations in accordance with the provisions of chapter 54 of the general statutes, for purposes of this section.

Sec. 9. Subsection (a) of section 19a-59b of the general statutes, as amended by section 2 of public act 90-13, is repealed and the following is substituted in lieu thereof:

(a) The commissioner of health services shall establish a maternal and child health protection program. He shall contract, for purposes of the program, annually, within available appropriations, with local providers of health services to provide outpatient maternal health services and labor and delivery services to needy pregnant women and child health services to children [, up to an age, not to exceed age five, determined by the commissioner] UNDER SIX YEARS OF AGE. Eligibility shall be limited to families who have an income equal to or less than one hundred eighty-five per cent of the poverty level, according to the federal Office of Management and Budget poverty guidelines for nonfarm families, who lack private, third party health insurance to cover such services. Such local providers shall determine eligibility for services under the program. The contracts shall include criteria for making such determination in accordance with this section. Outpatient

services provided under the program shall include at least the outpatient services provided to medical assistance recipients under chapter 302. The commissioner shall conduct an outreach program designed to educate the public with regard to the program and to encourage providers to participate in the program. The commissioner, in consultation with the commissioner of income maintenance, shall seek any federal matching funds available for the program.

Sec. 10. (NEW) The commissioner of health services may establish, within available appropriations, a direct services program to provide three-year grants to health care providers in order to expand access to health care for the uninsured. Providers under the program shall provide or arrange access to, primary and preventive services, referrals to specialty services, including rehabilitative and mental health services, inpatient care, prescription drugs, basic diagnostic laboratory services, health education and outreach to alert people to the availability of services. Participating providers shall serve the uninsured based on a sliding fee schedule. The grants may be used by the providers for operating expenses, recruitment of physicians and the subsidizing of physician's salaries and for capital expenditures. The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to establish eligibility criteria, services to be provided by participants, the sliding fee schedule and reporting requirements. For purposes of this section "provider" means a primary care clinician or a community based primary care provider organization.

Sec. 11. The commission on hospitals and health care may develop (1) a plan to lower the cost shift from Medicare to other payers and (2) a method to improve its data on hospital charges, payment by specific classes of payers, bad debt and free care writeoffs by hospitals. On or before March 1, 1991, the commission shall report on such developments to the joint

standing committee of the general assembly having cognizance of matters relating to public health.

Sec. 12. (NEW) As used in sections 12, 13, 17 to 23, inclusive, of this act, section 12-201 of the general statutes, as amended by section 14 of this act, section 12-211 of the general statutes, as amended by section 15 of this act and section 12-212a of the general statutes, as amended by section 16 of this act:

(1) "Pool" means the Connecticut small employer health reinsurance pool, established under section 23 of this act.

(2) "Board" means the board of directors of the pool.

(3) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty or more hours and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or contractor is included as an employee under a health care plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(4) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business who, on at least fifty per cent of its working days during the preceding year, employed no more than twenty-five eligible employees, the majority of whom were employed within the state of Connecticut. In determining the number of eligible employees, companies which are affiliated companies, as defined in section 33-374a of the general statutes, or which are eligible to file a combined tax return for purposes of taxation under chapter 208 of the general statutes shall be considered one employer. Except as otherwise specifically provided, provisions of sections 12, 13, 17 to 23, inclusive, of this act, section 12-201 of the general statutes, as amended by section 14 of this act, section 12-211 of the general statutes, as amended by section 15 of this act and section 12-212a of the general statutes, as amended by section 16 of this act, which apply to a small employer shall continue to

apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(5) "Insurer" means any insurance company, hospital or medical service corporation, or health care center, authorized to transact health insurance business in this state.

(6) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement which is fully insured within the meaning of Section 514(b)(6) of said act, as amended.

(7) "Health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include accident only, credit, dental or disability insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which beneficiaries are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(8) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to section 20 of this act.

(9) "Late enrollee" means an eligible employee or dependent who requests enrolment in a small employer's health insurance plan following the initial enrolment period provided under the terms of such plan, provided an eligible employee or dependent shall not be considered a late enrollee if (A) the request for enrolment is made within thirty days after termination of coverage provided under another group health insurance plan and if the individual had not initially requested coverage under such plan solely because he was covered under another group health insurance plan and coverage under that plan has ceased due to termination of employment, death of a spouse, or divorce, or (B) a court has ordered coverage be provided for a spouse or minor

child under a covered employee's plan and request for enrolment is made within thirty days after issuance of such court order.

(10) "Department" means the insurance department.

(11) "Special health care plan" means a health insurance plan for previously uninsured small employers, established by the board in accordance with section 13 of this act or by the Health Reinsurance Association in accordance with section 21 of this act.

(12) "Small employer health care plan" means a health insurance plan for small employers, established by the board in accordance with section 19 of this act.

(13) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health insurance plan covering such employee.

(14) "Commissioner" means the insurance commissioner.

(15) "Member" means each insurer and insurance arrangement participating in the pool.

(16) "Small employer carrier" means any insurer or insurance arrangement which offers group health insurance plans covering eligible employees of one or more small employers.

(17) "Pre-existing conditions provision" means a policy provision which excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinary prudent person to seek diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to a condition which is pregnancy existing on the effective date of coverage.

(18) "Base premium rate" means, as to any health insurance plan or insurance arrangement covering one or more employees of a small employer, the lowest new business premium rate charged by the insurer or insurance arrangement for the same or similar coverage which is equivalent in value under a plan or arrangement

covering any small employer with similar case characteristics, other than claim experience, as determined by such insurer or insurance arrangement.

(19) "Low-income eligible employee" means an eligible employee of a small employer whose annualized wages from such small employer determined as of the effective date of the special health care plan or as of any anniversary of such effective date as certified to the insurer or insurance arrangement or the Health Reinsurance Association, as the case may be, by such small employer is less than two hundred per cent of the federal poverty level applicable to such person.

(20) "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

(21) "Health Reinsurance Association" means the entity established and maintained in accordance with the provisions of chapter 692 of the general statutes.

(22) "Reimbursement rate" means, as to individuals covered under special health care plans or an individual special health care plan, seventy-five per cent of the Medicare reimbursement rate for benefits normally reimbursable under Medicare. For services or supplies not reimbursed by Medicare, such reimbursement shall be seventy-five per cent of the amount which would be payable under Medicare, if Medicare was responsible for benefit payments under such plans for such services and supplies, as determined by the board and approved by the Commissioner.

(23) "Individual special health care plan" means a health insurance plan for individuals, issued by the Health Reinsurance Association in accordance with section 22 of this act or issued by an insurer in accordance with section 13 of this act.

(24) "Low-income individual" means an individual whose annualized wages from all employers for the individual and spouse, determined as of the date of application for the individual special health care plan or as of any anniversary of the effective date of the plan, as certified by such individual,

is less than two hundred per cent of the applicable federal poverty level.

(25) "Medicare reimbursement rate" means the amount which would be payable under Medicare for benefits normally reimbursed under Medicare.

(26) "Health care center" means health care center as defined in section 33-179a of the general statutes.

Sec. 13. (NEW) (a) (1) In order to facilitate the provision of lower cost health insurance coverage for uninsured small employers, the board shall establish, subject to the approval of the commissioner, two special health care plans, one for use by health care centers and one for use by other small employer carriers. The board shall submit such plan to the commissioner for his approval within ninety days after the appointment of the board pursuant to section 20 of this act. The board shall take into consideration the levels of health care plans provided in Connecticut, including those provided by health care centers, as appropriate, and such medical and economic factors as may be deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, maximum copayment obligations and exclusions and limitations which the board considers appropriate for uninsured small employers, provided the level of reimbursement shall be based on the reimbursement rate. Benefit plans may include cost containment features such as, but not limited to: (A) Preferred provider provisions; (B) utilization review of health care services, including review of medical necessity of hospital and physician services; (C) case management benefit alternatives; and (D) other managed care provisions. The special health care plan established for use by health care centers shall be consistent with the basic method of operation and the benefit plans of health care centers.

(2) After the commissioner's approval of special health care plans submitted by the board pursuant to subdivision (1) of this subsection, and in lieu of the procedure established by section 38-174 of the general statutes, any small employer carrier may

certify to the commissioner, in the form and manner prescribed by the commissioner, that the special health care plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(b) (1) Within ninety days after approval by the commissioner of special health care plans submitted by the board, every small employer carrier shall, as a condition of transacting such business in this state, offer small employers the special health care plan, provided no small employer carrier may offer a special health care plan to a small employer with ten or fewer eligible employees, the majority of whom are low-income eligible employees. Such employers may purchase a special health care plan from the Health Reinsurance Association pursuant to section 21 of this act. Except as provided in subdivision (2) of this subsection, every small employer which elects to be covered under a special health care plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier or the Health Reinsurance Association, as the case may be.

(2) No small employer may be eligible to purchase a special health care plan unless such employer had maintained no health insurance coverage for its employees at any time during the two-year period ending on the date of application for such policy. No small employer may purchase a special health care plan for more than three years.

(3) No special health care plan may be sold with an initial effective date of January 1, 1995, or later.

(4) In addition to any other requirements related to the establishment of premiums for special health care plans issued by small employer carriers to small employers, (A) the anticipated loss ratio shall not be less than seventy-five per cent of the premium, and (B) small employer carriers shall file annually by

the end of March of each year information with the insurance department with respect to such plans for the prior calendar year including the number of plans issued, the anticipated loss ratio, the premiums earned, the paid and estimated outstanding claims, expenses charged, and such other information as the commissioner deems necessary to assure compliance with subparagraph (A) of this subdivision.

(5) A health care center shall not be required to offer coverage or accept applications pursuant to subdivision (1) of this subsection in the case of any of the following: (A) To a group, where the group is not physically located in the health care center's approved service area; (B) to an employee, where the employee does not work or reside within the health care center's approved service area; (C) within an area where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (D) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition or (E) to groups of fewer than three eligible employees, where the health care center does not utilize preexisting condition provisions in the plans it issues to any samll employers. A health care center that refuses to offer coverage pursuant to subparagraph (C) of this subdivision may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees.

(c) Insurers may issue individual special health care plans subject to the laws applicable to individual health insurance in this state, provided such policies shall be identical to the individual special health care plans made available by the Health Reinsurance Association pursuant to section 22 of this act.

Sec. 14. Section 12-201 of the general statutes is repealed and the following is substituted in lieu thereof:

When used in this chapter, unless the context otherwise requires, "commissioner of revenue services" or "commissioner" means the commissioner of revenue services; "insurance commissioner" means the state insurance commissioner; "taxpayer" means any insurance company subject to taxation under this chapter; "insurance company" means any corporation, association, partnership or combination of persons doing any kind or form of insurance business other than a fraternal benefit society, including a receiver, trustee or other fiduciary of any insurance company when the context reasonably permits; "domestic insurance company" means any insurance company chartered by or organized or constituted within or under the laws of this state; "local domestic insurance company" means any domestic insurance company more than fifty per cent of the total gross direct premiums of which are received during the calendar year next preceding for insurance on property or risks located or resident in this state; "gross direct premiums" means all receipts of premiums from policyholders and applicants for policies, whether received in the form of money or other valuable consideration, but excluding annuity premiums and considerations and premiums received for reinsurances assumed from other insurance companies AND PREMIUMS RECEIVED AFTER JULY 1, 1990, AND BEFORE JANUARY 1, 1995, FOR ANY SPECIAL HEALTH CARE PLAN, AS DEFINED IN SECTION 12 OF THIS ACT; "net direct premiums" means gross direct premiums less the following items: (1) Returned premiums, including cancellations, and (2) dividends paid to policyholders on direct business, not including any dividends paid on account of the ownership of stock; "received" means "received" or "accrued," construed according to the method of accounting customarily employed by the taxpayers; "domestic insurance holding company" means any company engaged principally in the business of holding the stocks of domestic insurance companies, whether or not such holding company is chartered in this state; "life insurance department" or "life

insurance company" means any department or company engaged in writing policies or annuities the premiums on which are charged wholly or chiefly on the basis of tables purporting to represent the mortality of insured lives or of annuitants; "state" means any state, territory or district of the United States; and "ocean marine insurance" means all insurance written within this state upon hulls, freights or disbursements, or upon goods, wares, merchandise and all other personal property and interests therein, in course of exportation from or importation into any country or transportation coastwise, including transportation by land or water from point of origin to final destination, in respect to any and all risks or perils of navigation, transit or transportation, and while being prepared for and awaiting shipment, and during any delays, storage, transshipment or reshipment incident thereto, including war risks and marine builder's risks.

Sec. 15. Section 12-211 of the general statutes is repealed and the following is substituted in lieu thereof:

When by the laws of any other state or foreign country any premium or income or other taxes or any fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions are imposed upon Connecticut insurance companies doing business in such other state or foreign country, or upon the authorized agents thereof, which are in excess of such taxes, fees, fines, penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon insurance companies, or upon the authorized agents thereof, of such other state or foreign country doing business in Connecticut, so long as such laws continue in force the same obligations, prohibitions and restrictions of whatever kind, computed by the commissioner of revenue services on an aggregate state-wide or foreign-country-wide basis, shall be imposed upon insurance companies and authorized agents thereof of such other state or foreign country doing business in Connecticut. Any tax obligation imposed by any city, county or other political

subdivision of a state or foreign country on Connecticut insurance companies shall be deemed to be imposed by such state or foreign country within the meaning of this section. For the purposes of this section, the domicile of a foreign insurer shall be that state designated by the insurer in writing filed with said commissioner at the time of admission to this state or within six months after July 1, 1973, whichever date is later, and may be any one of the following states: (1) That in which the insurer was first authorized to engage in the insurance business; (2) that in which the principal place of business of such insurer in the United States is located; (3) that in which the largest deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States is held. Any designation so made hereunder shall be irrevocable and, if the insurer makes no such designation at or within the time provided herein, its domicile shall irrevocably be deemed to be that state in which the insurer was first authorized to engage in the insurance business in the United States. The domicile of an insurer formed under the laws of Canada or a province thereof shall be deemed to be that province in which its head office is situated. The provisions of this section shall not apply to ad valorem taxes on real or personal property, personal income taxes, fees for agents' licenses, [or] special purpose assessments imposed in connection with particular kinds of insurance including, but not limited to, workers' compensation assessments and insurance guaranty association fund assessments, OR TO PREMIUM TAXES ON SPECIAL HEALTH CARE PLANS AS DEFINED IN SECTION 12 OF THIS ACT.

Sec. 16. Section 12-212a of the general statutes is repealed and the following is substituted in lieu thereof:

All corporations organized under chapters 592 and 593 shall pay to the commissioner of revenue services on or before March first, annually, a charge at the rate of two per cent of the total net direct subscriber charges, EXCLUDING THOSE NET DIRECT SUBSCRIBER CHARGES RECEIVED AFTER JULY 1, 1990, AND BEFORE

JANUARY 1, 1995, FROM EMPLOYERS FOR ANY SPECIAL HEALTH CARE PLAN, AS DEFINED IN SECTION 12 OF THIS ACT, received by such corporation during the next preceding calendar year, which shall be in addition to any other payment required under section 38-53b. The charge required under this section and any other payment required under said section 38-53b shall be in compensation for the costs and expenses of regulation by the insurance department and all other governmental services. The provisions of this chapter pertaining to the filing of returns, declarations, assessment and collection of taxes, and penalties imposed on domestic insurance companies shall apply with respect to the charge imposed under this section, provided corporations subject to the charge imposed under this section shall not be subject to any tax imposed under this chapter.

Sec. 17. (NEW) (a) Any individual or group health insurance plan or any insurance arrangement shall be subject to the provisions of sections 12, 13, 17 to 23, inclusive, of this act, section 12-201 of the general statutes, as amended by section 14 of this act, section 12-211 of the general statutes, as amended by section 15 of this act and section 12-212a of the general statutes, as amended by section 16 of this act, if it provides health insurance or is an insurance arrangement covering one or more employees of a small employer and if any one of the following conditions are met:

(1) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(2) The health insurance plan or arrangement is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

(b) Nothing in this section shall be interpreted to apply the provisions of sections 12-202 and 12-212a of the general statutes to health care centers.

Sec. 18. (NEW) Health insurance plans and insurance arrangements covering small employers shall be subject to the following provisions:

(1) Except in the case of a late enrollee, any pre-existing conditions provision may not exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves or for which medical advice, diagnosis, case or treatment was recommended or received during the six months immediately preceding the effective date of coverage or to pregnancy existing on the effective date of coverage.

(2) In determining whether a pre-existing conditions provision applies to an eligible employee or dependent, all plans and arrangements shall credit the time such person was covered under a previous group health insurance plan or arrangement as a resident of Connecticut if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan.

(3) Any such plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the policy-holder or contract-holder except: (A) For nonpayment of the required premiums by the policy-holder or contract-holder; (B) for fraud or misrepresentation of the policy-holder or contract-holder or, with respect to coverage of individual insured, the insureds or their representatives; (C) for noncompliance with plan or arrangement provisions; (D) when the number of insured covered under the plan or arrangement is less than the number of insureds or percentage of insureds required by participation requirements under the plan or arrangement; or (E) when the policy-holder or contract-holder is no longer actively engaged in the business in which it was engaged on the effective date of the plan or arrangement.

(4) Except in the case of a late enrollee, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person.

(5) The premium rates charged or offered for a rating period may not exceed two hundred per cent of the base premium rate for such rating period, as to: (A) All plans or arrangements issued on or after July 1, 1990, and (B) beginning July 1, 1995, plans or arrangement issued prior to July 1, 1990.

(6) Subject to the provisions of subdivision (7) of this section, no increase in premium rates for a new rating period may exceed the sum of: (A) Any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus an amount determined as twenty per cent, adjusted as appropriate for rating periods greater or lesser than one year, of the base premium rate for such new rating period and (B) any adjustment due to change in case characteristics, other than claim experience, or coverage of the small employer, as determined by the insurer.

(7) With respect to plans or arrangements issued prior to July 1, 1990, in any case where premium rates for a rating period commencing on or after said date exceed two hundred per cent of the base premium rate, no increase in premium rates for a new rating period may exceed the sum of: (A) Any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus (B) any adjustment due to change in case characteristics, other than claim experience, or coverage of the small employer, as determined by the insurer.

(8) The provisions of subdivisions (5) to (7), inclusive, of this section shall not apply to the extent that the limitations in said subdivisions are exceeded due to charges for reinsurance by the pool.

(9) In any case where an insurer issues or offers a policy or contract under which premium rates for a specific small employer are established or adjusted in part based upon the actual or expected variation in claim costs or actual or expected variation in health conditions of the employees or dependents of such small employer, the insurer shall make reasonable disclosure of such rating practices in solicitation and sales materials utilized with respect to such policy or contract.

(10) The provisions of subdivisions (1), (3) and (9) of this section shall apply to plans and arrangements delivered, issued for delivery, renewed or continued in this state on or after July 1, 1990. The provisions of subdivisions (2) and (4) of this section shall apply to plans and arrangements delivered, issued for delivery, renewed or continued in this state on or after the date the pool is operational, as designated by the commissioner. For purposes of this subdivision, the date a plan or arrangement is continued shall be the anniversary date of the issuance of the plan or arrangement.

Sec. 19. (NEW) (a) (1) Subject to approval by the commissioner, the board shall establish the form and level of coverages to be made available by small employer carriers in accordance with the provisions of subsection (b) of this section. Such coverages, which shall be designated as small employer health care plans, shall be limited to: (A) A basic hospital plan, (B) a basic surgical plan, (C) major medical plans which can be written in conjunction with basic hospital plans or basic surgical plans, (D) comprehensive plans, and (E) plans with benefit and cost sharing levels which are consistent with the basic method of operation and the benefit plans of health care centers, including any restrictions imposed by federal law. The board shall submit such plans to the commissioner for his approval within ninety days after the appointment of the board pursuant to section 20 of this act. The board shall take into consideration the levels of health insurance provided in Connecticut and such medical and economic factors as may be

deemed appropriate and shall establish benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of health insurance provided to small employers. Such plans may include cost containment features such as, but not limited to: (i) Preferred provider provisions; (ii) utilization review of health care services, including review of medical necessity of hospital and physician services; (iii) case management benefit alternatives; and (iv) other managed care provisions.

(2) After the commissioner's approval of small employer health care plans submitted by the board pursuant to subdivision (1) of this subsection, and in lieu of the procedure established by section 38-174 of the general statutes, any small employer carrier may certify to the commissioner, in the form and manner prescribed by the commissioner, that the small employer health care plans filed by the carrier are in substantial compliance with the provisions in the corresponding approved board plan. Upon receipt by the department of such certification, the carrier may use such certified plans until such time as the commissioner, after notice and hearing, disapproves their continued use.

(b) Within ninety days after the commissioner's approval of small employer health care plans submitted by the board, every small employer carrier shall, as a condition of transacting such insurance in this state, offer those small employer health care plans that correspond to the insurance products being currently offered by the carrier to small employers. Every small employer which elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier.

(c) No health care center shall be required to offer coverage or accept applications pursuant to subsection (b) of this section in the case of any of the following: (1) To a group, where the group is not physically located in the health care center's approved service area; (2) to an employee, where the employee

does not work or reside within the health care center's approved service area; (3) within an area, where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (4) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition or (5) to groups of fewer than three eligible employees, where the health care center does not utilize preexisting condition provisions in the plans it issues to any small employers. A health care center that refuses to offer coverage pursuant to subdivision (3) of this subsection may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than twenty-five eligible employees.

Sec. 20. (NEW) (a) (1) There is established a nonprofit entity to be known as the "Connecticut Small Employer Health Reinsurance Pool". All insurers issuing health insurance in this state and insurance arrangement providing health plan benefits in this state on and after July 1, 1990, shall be members of the pool.

(2) On or before July 15, 1990, the commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meeting, which shall take place by September 1, 1990. The members shall select the initial board, subject to approval by the commissioner. The board shall consist of at least five and not more than nine representatives of members. There shall be no more than two members of the board representing any one insurer or insurance arrangement. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be weighted based upon net health insurance premium derived from this state in the previous calendar year. To the extent

possible, at least one-third of the members of the board shall be domestic insurance companies and at least two-thirds of the members of the board shall be small employer carriers. At least one member of the board shall be a health care center and at least one member shall be a small employer carrier with less than one hundred million dollars in net small employer health insurance premium in this state. The net premium amount shall be adjusted by the board periodically for health care cost inflation. In approving selection of the board, the commissioner shall assure that all members are fairly represented.

(3) If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within fifteen days of the organizational meeting.

(4) Within ninety days after the appointment of such initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided he determines it to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (d) of this section. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments, as appropriate. The commissioner shall amend any plan adopted by him, as necessary, at the time a plan of operation is submitted by the board and approved by the commissioner.

(5) The plan of operation shall establish procedures for: (A) Handling and accounting of assets and moneys of the pool, and for an annual fiscal reporting to the commissioner; (B) filling vacancies on the board, subject to the approval of the commissioner; (C) selecting an administering insurer and setting forth the powers and duties of the administering insurer; (D) reinsuring risks in accordance with the provisions of this section; (E) collecting assessments from all members to provide for claims reinsured by the pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made and (F) any additional matters at the discretion of the board.

(6) The pool shall have the general powers and authority granted under the laws of Connecticut to insurance companies licensed to transact health insurance and, in addition thereto, the specific authority to: (A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this section, including the authority, with the approval of the commissioner, to enter into contracts with similar functions, or with persons or other organizations for the performance of administrative functions; (B) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members; (C) take such legal action as necessary to avoid the payment of improper claims against the pool; (D) define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this section; (E) establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the pool; (F) establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the pool; (G) assess members in accordance with the provisions of subsection (d) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any

such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year; (H) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool; and (I) borrow money to effect the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(b) Any member may reinsure with the pool coverage of an eligible employee of a small employer, or any dependent of such an employee, provided:

(1) With respect to a special health care plan or a small employer health care plan, the pool shall reinsure the level of coverage provided; with respect to other plans, the pool shall reinsure the level of coverage provided, up to but not exceeding, the level of coverage provided in a small employer health care plan;

(2) With respect to eligible employees, and their dependents, who are employed by a small employer as of the date such employer's coverage by the member commences and enroll in a manner such that they are not considered to be late enrollees to the plan, coverage may be reinsured: (A) Within thirty days of the commencement of such employer's coverage with the member or (B) commencing July 1, 1991, on any plan anniversary after the employer's coverage has been in effect for a period of three years;

(3) With respect to eligible employees, and their dependents, who are hired subsequent to the commencement of such employer's coverage by the member, and with respect to such employees and dependents who are considered to be late enrollees to the plan, or would be considered to be late enrollees to the plan but for the provisions of subdivision (9) of section 12 of this act, coverage may be reinsured: (A) Within thirty days of the

commencement of their coverage under the plan or (B) commencing July 1, 1991, on any plan anniversary after the employer's coverage has been in effect for a period of three years; and

(4) No member may reinsure the health insurance coverage of all of the eligible employees, and their dependents, of any small employer unless such coverage is provided under a special health care plan or a small employer health care plan.

(c) Except as provided in subsection (d) of this section, premium rates charged for reinsurance by the pool shall be established at the following percentages of the rate established by the pool for that classification or group with similar characteristics and coverage:

(1) One hundred fifty per cent, with respect to all of the eligible employees, and their dependents, of a small employer, all of whose coverage is reinsured in accordance with subdivision (2) or (3) of subsection (b) of this section.

(2) One hundred fifty per cent, with respect to an eligible employee or dependent who was not a late enrollee, was not insured for a period of at least thirty-one days immediately preceding commencement of his coverage under the small employer's plan, exclusive of any applicable waiting period under such plan, and is reinsured in accordance with subparagraph (A) of subdivision (2) of subsection (b) or subparagraph (A) of subdivision (3) of subsection (b) of this section; and

(3) Five hundred per cent, with respect to an eligible employee or dependent who was a late enrollee, or, except as provided in subdivision (1) of this subsection, was insured during the thirty-day period immediately preceding commencement of his coverage under the small employer's plan, exclusive of any applicable waiting period under such plan, or is reinsured in accordance with subparagraph (B) of subdivision (2) of subsection (b) or subparagraph (B) of subdivision (3) of subsection (b) of this section.

(d) Premium rates charged for reinsurance by the pool to a health care center which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300 et seq., and as such is subject to requirements that limit the amount of rish that may be ceded to the pool, shall be reduced to reflect the portion of risk that may be ceded to the pool.

(e) In any case where health insurance coverage for a small employer issued in accordance with this section is entirely or partially reinsured with the pool, the premium charged to the small employer for any rating period for the coverage issued in accordance with this section shall be no more than the premium established by the pool in accordance with this section, provided the premium charged the small employer for any individual reinsured under subparagraph (B) of subdivision (2) of subsection (b) or subparagraph (B) of subdivision (3) of subsection (b) of this section shall be no more than one hundred fifty per cent of the rate established by the pool for that classification or group with similar characteristics and coverage.

(f) (1) Following the close of each fiscal year, the administering insurer shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health insurance premiums earned by insurance arrangements shall be established by adding paid health losses and administrative expenses of the insurance arrangement. Health insurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this subsection, "net premiums" means health insurance premiums, less administrative expense allowances.

(2) Any net loss for the year shall be recouped by assessments of members. (A) Assessments shall first be apportioned by the board among all members in proportion to their

respective shares of the total health insurance premiums earned in this state from health insurance plans and insurance arrangements covering small employers during the calendar year coinciding with or ending during the fiscal year of the pool, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operations. An assessment shall be made pursuant to this subparagraph against a health care center, which is approved by the Secretary of Health and Human Services as a health maintenance organization pursuant to 42 USC 300e et seq., subject to an assessment adjustment formula adopted by the board and approved by the commissioner for ushc health care centers which recognizes the restrictions imposed on such health care centers by federal law. Such adjustment formula shall be adopted by the board and approved by the commissioner prior to the first anniversary of the pool's operation. (B) If such net loss is not recouped before assessments totaling five per cent of such premiums from plans and arrangements covering small employers have been collected, additional assessments shall be apportioned by the board among all members in proportion to their respective shares of the total health insurance premiums earned in this state from other individual and group plans and arrangements, exclusive or any individual Medicare supplement policies as defined in section 38-174m of the general statutes during such calendar year. (C) Notwithstanding the provisions of this subdivision, the assessments to any one member under subparagraphs (A) or (B) of this subdivision shall not exceed forty per cent of the total assessment under each subparagraph for the first fiscal year of the pool's operation and fifty per cent of the total assessment under each subparagraph for the second fiscal year. Any amounts abated pursuant to this subparagraph shall be assessed against the other members in a manner consistent with the basis for assessments set forth in this subdivision.

(3) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(4) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Insurance arrangements shall report to the board claims payments made and administrative expenses incurred in this state on an annual basis on a form prescribed by the commissioner.

(5) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(6) The board may defer, in whole or in part, the assessment of a health care center if, in the opinion of the board: (A) Payment of the assessment would endanger the ability of the health care center to fulfill its contractual obligations, or (B) in accordance with standards included in the plan of operation, the health care center has written, and reinsured in their entirety, a disproportionate number of special health care plans. In the event an assessment against a health care center is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this subsection. The health care center receiving such deferment shall remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferment.

(g) (1) Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this section shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

(2) Any person or member made a party to any action, suit, or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, wilful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members.

Sec. 21. (NEW) Notwithstanding the provisions of chapter 692 of the general statutes, the Health Reinsurance Association may issue special health care plans to small employers with ten or fewer eligible employees, the majority of whom are low-income eligible employees. The following provisions shall apply to such special health care plans:

(1) Premium rates shall be promulgated by the board of directors of the Health Reinsurance Association based on recommendations of its actuarial committee. In developing recommendations for premium rates, the actuarial committee shall consider, in addition to other pertinent matters, the premiums that are or would be charged for the same or similar insurance by other insurers. Except as otherwise provided in sections 12, 13, 17 to 23, inclusive, of this act, in establishing premium rates the board of directors of the Health Reinsurance Association may consider any relevant factors impacting premium, claims and expenses, including characteristics of small employers and insureds, that may be considered by any insurer in establishing health insurance premium rates. The premium rates established shall be subject to the provisions of section 18 of this act. The anticipated loss ratio shall not be less than eighty per cent of

the premium. In establishing premium rates it shall be the goal of the board of directors of the Health Reinsurance Association to administer special health care plans issued to small employers without gain or loss; and

(2) The Health Reinsurance Association may reinsure coverage of special health care plans with the pool.

Sec. 22. (NEW) In addition to the options for individual comprehensive health care plans, the Health Reinsurance Association shall make available to individuals, on the same terms and conditions as are applicable to the other individual comprehensive health care plan options under chapter 692 of the general statutes, including the provisions for establishment and filing of premium rates, the option to purchase an individual special health care plan identical to the special health care plan for small employers established in accordance with section 13 of this act. The requirement that coverage not have been maintained for a two-year period contained in subdivision (2) of subsection (c) of section 13 of this act shall not apply to individual special health care plans.

Sec. 23. (NEW) No individual or organization which provides medical advice, diagnosis, care or treatment of a type which is covered under special health care plans may, on or after July 1, 1990, provide such service to any person in this state unless such individual or organization would, upon request, provide such service, on the basis of the applicable reimbursement rate, to low-income eligible employees or their dependents covered under special health care plans or low income individuals or their dependents covered under individual special health care plans.

Sec. 24. Subsection (b) of section 38-372 of the general statutes is repealed and the following is substituted in lieu thereof:

(b) Every carrier offering group health insurance in this state shall, as a condition of transacting such health insurance, make a group comprehensive health care plan, as described in section 38-374, available to every resident employer of three or

more eligible employees. An employer shall have the choice of the low option or middle option or high option deductible described in subsection (b) of section 38-373. [Group comprehensive health care plans may be made available to resident employers of between three and twenty-five eligible employees through participation in the Health Reinsurance Association, in accordance with section 38-376 or the residual market association, in accordance with section 38-377. The premium charged for such a plan on groups of between three and twenty-five eligible employees which is not insured by or through the Health Reinsurance Association or a residual market association may not exceed the premium which would be applicable through participation in such associations. The premium charged for such a plan which is insured by or through the Health Reinsurance Association must be precisely the premium established for that particular classification under the Health Reinsurance Association.]

Sec. 25. Subsection (c) of section 38-376 of the general statutes is repealed and the following is substituted in lieu thereof:

(c) Every member shall participate in the association in accordance with the provisions of this subdivision. (1) A participating member shall determine the particular risks it elects to have written by or through the association. A member shall designate which of the following classes of risks it shall underwrite in the state, from which classes of risk it may elect to reinsure selected risks: (A) Individual, excluding group conversion; AND (B) individual, including group conversion. [; and (C) groups of between three and twenty-five employees or members.] (2) No member [or employer] shall be permitted to select out individual lives from an employer group to be insured by or through the association. Members electing to administer risks which are insured by or through the association shall comply with the benefit determination guidelines and the accounting procedures established by the association. A risk insured by or through the association cannot be withdrawn by the

participating member except in accordance with the rules established by the association. (3) Rates for coverage issued by or through the association shall not be excessive, inadequate or unfairly discriminatory. Separate scales of premium rates based on age shall apply [for individual risks and group risks. Group rates may be adjusted for area variations in provider costs] but [individual] rates shall not be adjusted for area variations in provider costs. Premium rates shall take into consideration the substantial extra morbidity and administrative expenses for association risks, reimbursement or reasonable expenses incurred for the writing of association risks and the level of rates charged by insurers for groups of ten lives, provided incurred losses which result from provision of coverage in accordance with section 38-262c shall not be considered. In no event shall the rate for a given classification or group be less than one hundred twenty-five per cent nor more than one hundred fifty per cent of the average [group] rate charged for that classification [or group] with similar characteristics under a policy covering ten lives. All rates shall be promulgated by the association through an actuarial committee consisting of five persons who are members of the American Academy of Actuaries, shall be filed with the commissioner and may be disapproved within sixty days from the filing thereof if excessive, inadequate, or unfairly discriminatory.

Sec. 26. On or after July 1, 1993, the joint standing committees of the general assembly having cognizance of matters relating to insurance and public health shall conduct a study of the effectiveness of the provisions of sections 12 to 17, inclusive, of this act, in addressing and reducing the problem of the health uninsured in Connecticut. The study shall include, but not be limited to, an examination of the numbers and types of employers who purchased the special health care plans offered pursuant to section 13 of this act in the prior three years and the number of persons insured by such plans during that period. On or before February 1, 1994, the committees shall issue a joint

report to the general assembly on their findings and any recommendations for the continuation, modification or elimination of the special health care plan program.

Sec. 27. The sum of thirty-five thousand dollars is appropriated to the department of health services for the fiscal year ending June 30, 1991, from the sum appropriated to the finance advisory committee under section 1 of substitute house bill 5149 of the current session, for 1990 acts without appropriations, for a health planner services.

Sec. 28. The sum of twenty-five thousand dollars is appropriated to the joint committee on legislative management for the fiscal year ending June 30, 1991, from the sum appropriated to the finance advisory committee under section 1 of substitute house bill 5149 of the current session, for 1990 acts without appropriations, for the health access commission established pursuant to section 2 of this act.

Sec. 29. This act shall take effect July 1, 1990, except that section 8 shall take effect July 1, 1991."

64th OREGON LEGISLATIVE ASSEMBLY-1987 Regular Session

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-

182X

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

184 X

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.

186X

Communications Workers of America

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Testimony of Alan Kaufman

on Behalf of the

Communications Workers of America

Before the Assembly Health Care Policy Study Commission

Wednesday, July 18, 1990

Good morning! My name is Alan Kaufman and I am the New Jersey Health Care Benefits Coordinator of the Communications Workers of America, AFL-CIO. I would like to thank the members of this Commission for the opportunity to share CWA's views on the problems of access to health care in this state.

CWA represents approximately 60,000 public and private sector workers in New Jersey who are covered under a variety of health insurance programs negotiated with many separate employers. All of our Union is deeply concerned with the problems of our current health care system and with the prospect of maintaining, let alone

improving, the current level of negotiated benefits. In fact, there is no other single issue around which our rank-and-file will more quickly mobilize than that of maintaining health insurance coverage.

As you may be aware, the CWA rank-and-file recently concluded a 116 day strike against the health care takeback demands put on the table by the NYNEX Company. Such militancy and concern around the health care issue is not limited to CWA, as health care givebacks was a major issue in the recently concluded strike of Virginia coal miners at Pittson Company.

In 1986, employer demands for health care takebacks were the prime factors in work stoppages involving 18% of all striking workers. By 1989, that number was up to 78%.

These statistics are testimony to the abject failure of our health care system. Of course, the failure of all the various cost containment schemes, from HMO's, PPO's, DRG's, mandatory second opinion, managed care, etc., has left us with a system where health costs routinely rise 20-40% per year. I can honestly state that I have been relieved to hear from the management side during negotiations recently that their premium costs for health insurance rose 20%, because I have heard 40%.

198X

The escalating costs of health care make it the number one issue at the bargaining table.

We have increasingly seen demands for increased deductibles, worker payment for all future premium increases, change to inferior benefit programs, or as an alternative, significantly lower wage increases. A few years back, Governor Kean's Management Improvement Plan suggested such cost shifting proposals for the State Health Benefits Plan under which over 300,000 state and local government workers now receive coverage.

A recently released "Report of the Task Force on the Equitable Management of Revenues and Expenditures" suggested that public employees making more than $30,000 per year be taxed a certain percentage rate like is done with unemployment and disability insurance. This proposal is not too dissimilar from national proposals to consider benefit payments as taxable income.

If things are bad and getting worse for organized workers, what about those workers who are not covered by a union contract with a negotiated health benefits package? While estimates vary, it is generally agreed that of the 37 million Americans or 900,000 New Jersey residents with no health insurance coverage, up to two

thirds are working. Not only do people in this category not have any health insurance, the cost of their uncompensated care is worked into the premiums of those workers (and everyone else who is insured) who are covered.

The totally unacceptable situation of having anyone living in the United States or New Jersey uninsured for health care is probably a major factor contributing to the shocking statistics about quality of health in New Jersey (and in the United States) revealed in a May, 1990 report issued by Citizen Action, "Spending More and Getting Less: A Comparison of the Cost and Quality of Health Care in New Jersey, the United States, and the World."

"In New Jersey

- Per capita health care spending in New Jersey is greater than in any nation in the world;

- New Jersey lags behind 17 nations in infant mortality. Of counties with a population over 5,000, the worst infant mortality rates are in Salem, Essex and Hudson counties;

- New Jersey lags behind 16 nations in child mortality. Of Counties with a population over 5,000, the worst child mortality rates are in Salem, Essex and Cumberland counties;

- New Jersey lags behind 28 nations in percentage of low birthweight babies. Of counties with over 5,000 people, the highest percentage of low birthweight babies are in Essex, Hudson nd Mercer counties."

In short, we have a health care crisis whether we take a national or state perspective. We are paying an increasing percentage of our resources on health care while at the same time more and more of our citizens find themselves without any coverage and the quality of our care overall compares poorly with the rest of the world.

One of the questions posed in your "Notice of a Public Hearing" is "what level health care insurance coverage is or should be provided to employees." I want to discuss this question, in part, from an historical perspective. There was a time when labor's political agenda included a national health insurance program. The last serious drive for such a program on the part of labor ended shortly after World War II and the stronger unions fell back on an industry by industry system of privatized comprehensive health benefits plans negotiated across the bargaining table.

As was stated earlier, the last 10 years has seen an erosion of labor's benefit levels whether they be in plans covered through traditional insurance or whether they be the union's own health and retirement funds.

We can no longer look to the bargaining table to find a solution to health care coverage. The system is a failure. The health benefits coverage that should be provided to workers should be the same as provided to everyone. What we need is a universal, comprehensive system, not one system for the employed, another for the poor, another for the unemployed and yet another for the wealthy.

As for the question of the feasibility of establishing a mandatory level of health care coverage, all people should be entitled to all medically needed procedures.

In conclusion, my basic argument is that we are at a cross roads and when it comes to a policy decision on health care coverage. I think we must say the current road we are on is a dead end with prospects only for more of the same problems about which I am sure people have testified.

The unions must do everything in their power to fight concessions in the level of health care benefits and not allow any cost shifting. But unless we actively take an educational and mobilization plan to our members around the issue of a comprehensive and universal health system we will be unable in the long run to ensure that our present members are adequately covered or that newly organized workers receive even the level of benefits which are contractually in force now. This position is now reemerging in the labor movement and people are in the process of formulating the specifics of such a plan.

There is also a sentiment that absent a prospect for a national plan in the near future there should be attempts to develop model programs on a statewide level.

I think this Commission must consider the alternative of a Universal Comprehensive Health Care System for New Jersey. There is really no acceptable rationale to continue down the road of patchwork health care programs.