December, 1967

His Excellency Governor Richard J. Hughes
and the Honorable Members of the Senate
and General Assembly:

Pursuant to P.L. 1965, c. 140, the Commission to Study the Advisability of State Aid to Public and Non-Profit Private Hospitals for the Care of Indigent Patients herewith submits its final report and recommendations.

Respectfully submitted,

ASSEMBLYMAN NORMAN TANZMAN, Chairman
SENATOR JOHN A. LYNCH
SENATOR MILTON WOOLFENDEN
ASSEMBLYMAN RAYMOND H. BATEMAN
SISTER PATRICIA AIDAN, R.N.M.H.A.
ROBERT E. HEINLEIN
GEORGE OTLOWSKI
CHARLOTTE B. SIMON

CHAPTER 140
LAWS OF NEW JERSEY-1965

AN ACT creating a commission to study the advisability of State aid to public and nonprofit private hospitals for the care of indigent patients, prescribing its powers and duties, and making an appropriation therefor.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. There is hereby created a commission to consist of 2 members of the Senate, appointed by the President thereof, 2 members of the General Assembly, appointed by the Speaker thereof, and 4 citizens of this State having experience in hospital administration, appointed by the Governor, no more than one of each group of 2, nor 2 of the group of 4, being of the same political party. All of the members of the commission shall serve without compensation but they shall be entitled to be reimbursed for all necessary expenses incurred in the performance of their duties.

Vacancies in the membership of the commission shall be filled in the same manner as the original appointments were made.

2. The commission shall organize as soon as may be after the appointment of its members and shall select a chairman from among its members and a secretary who need not be a member of the commission.

3. It shall be the duty of said commission to define the term "indigent patient" for the purpose of any possible State aid for the cost of care therefor, determine the total cost of hospital care for indigent patients and make a study of the advisability of State aid to public and nonprofit hospitals for the care of indigent patients.

4. The commission shall be entitled to call to its assistance and avail itself of the services of such employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be available to it for said purpose, and to employ such professional, technical, stenographic and clerical assistants and incur such traveling and other miscellaneous expenses as it may deem necessary, in order to perform its duties, and as may be within the limits of funds appropriated or otherwise made available to it for said purposes.

5. The commission may meet and hold hearings at such place or places as it shall designate during the sessions or recesses of the Legislature and shall report its findings and recommendations to the Legislature, accompanying the same with any legislative bills which it may desire to recommend for adoption by the Legislature.

6. This act shall take effect immediately.

Approved July 13, 1965.

ACKNOWLEDGMENTS

AND

INTRODUCTION

The members of the Commission to Study the Advisability of State Aid to Public and Non-Profit Private Hospitals for the Care of Indigent Patients would like to express its appreciation to the New Jersey Hospital Association, the Hospital Service Plan of New Jersey, the Prudential Life Insurance Company, the New Jersey Nursing Home Association, Rutgers University, and to all the officials of the State of New Jersey who offered their cooperation in our study of this complex problem. The Commission would also like to thank the witnesses who appeared before it at its various hearings and especially those public professional persons who took the time to travel to either Rutgers University or Trenton to give testimony and advice in our endeavors.

The Commission would especially like to acknowledge the assistance of Dr. Lloyd B. McCorkle, Commissioner of the Department of Institutions and Agencies, and Irving J. Engelman, Director of the Division of Public Welfare in that Department. Their expertise and generous cooperation were of inestimable value in our deliberations.

This is the final report of this Commission. Since its establishment in 1965, it has studied the complex interrelated issues of aid to public and private non-profit hospitals for the care of indigent patients. The Commission had available to it the findings of earlier commissions concerned with issues related to this subject.

Since World War II, there have been a number of commissions that have concerned themselves with problems and issues related to rising hospital costs and availability of public funds to assist hospitals. Rather than traveling over these already explored routes, this Commission addressed itself primarily to the possible impact of the Title XIX amendments of 1965 to the Social Security Act on the hospital care of indigent patients. This program, authorized by the Federal Congress in 1965, has become commonly known as Medicaid. In a nutshell these amendments make it possible for states to enact enabling legislation to authorize a program of medical coverage for both the indigent and "medically indigent". The adoption of such a program by New Jersey will make available to hospitals payments at reasonable cost for the care of indigent patients. Since the cost to New Jersey of a Medicaid program will be high, this Commission also reviewed and reports on costs, persons covered and the scope of services of various program designs for Medicaid. It is hoped that the adopted Title XIX or Medicaid program in New Jersey will include provisions for the recommendations made by this Commission which relate to its area of study--hospitals and the indigent patient.

DISCUSSION OF FINDINGS

Financing hospital care is intimately related to a variety of socio-economic and demographic factors. Accordingly, a brief summary of several of these factors and some of the changes which are taking place in New Jersey is pertinent to an analysis of the problem.

Sections of the State have become part of that shifting, sprawling, urbanized complex of the northeastern seaboard now known as Megalopolis. In New Jersey, the outline of Megalopolis is a twenty-mile-wide strip running the length of the State. Two-thirds of the State's 6,800,000 people live in this area. New Jersey's population density is the highest of any State in the Union. In Hudson County, for instance, density approximates 14,000 people per square mile. New Jersey has been moving consistently toward increased urbanization and denser suburban communities. Larger, more complex cities and crowded suburban areas are developing.

The State's population increase during the last decade was approximately one and a quarter million persons. This rate of growth is due both to the excess of births over deaths and to an influx of new people. In addition, the population of New Jersey itself is highly mobile--large numbers of persons in our State move between counties and within counties. One trend which is particularly discernible in this mobility has been a mass exodus from farms into urban areas, from farming and private housework into offices and factories.

New Jersey's cities have become increasingly congested as people from lower income groups pour in, looking for employment. As these groups have been moving into the cities, there has been a loss of middle income families to the suburbs. Central city is less and less able to attract and hold residents other than the underprivileged.

Although some of the central cities are experiencing a slight decline in population density, it cannot be shown that this decline is occuring in seriously deteriorated neighborhoods. Personal income is increasing and affecting both the choice of housing locations and the amount and pattern of commercial activity.

Within the central cities the population appears to be becoming increasingly diverse. The young single person, the widowed and divorced, the couple without children, the expectant couple, the aged, the broken family and myriad others have tended to congregate there. All of these have replaced the average family in much of the housing.

In addition to changes in the pattern of urban-rural settlement, there have been changes in the composition of the population. Proportionately, the greatest increase in population has been in the dependent young and the dependent aged. During the 1950's New Jersey saw the phenomenon of an aging population, with elderly persons increasing in relation to the rest of the population. With the new rise in the numbers in the younger age group, New Jersey will begin to see a decrease in the average age of the population. As expressed by the demographers, New Jersey will see a "younging" of the population.

While New Jersey ranks second among the 50 states in per family income and sixth in per capita income, the number of families in New Jersey that fall below the National poverty level is approximately 180,400 (1960 census), or 11.4 percent. If one adjusts the National poverty level from $3,000 to a more realistic figure of $4,000, for New Jersey, the number of families below this line was 288,600 or 18.3 percent.

A more recent study made by the Bureau of the Census in March 1965 shows an increase from the 1960 percent at poverty levels; 13 percent of white families and 24 percent of negro families earn less than $3,000 in the north and western region of the country. Using $4,000 as the poverty level, the Census Bureau found that 20.1 percent of white families and 37.5 percent of negro families earn less than $4,000 a year. (Bureau of the Census, Series P-20 No. 155, September 23, 1966.) These are the families that appropriately need welfare services of all varieties.

Economic conditions are revealed particularly by rates of unemployment. The unemployment rate in New Jersey is estimated at 4.5 percent; this figure, however, has to be related to geographic areas in the State to discern its differential impact. In Newark, for instance, 8 percent of the working force is unemployed. Since National data reveals that non-white unemployment is approximately double the degree of unemployment for whites, the unemployed among Newark's non-whites attains even larger proportions and has its effect on caseload levels. This same situation, perhaps to a lesser extent, is true in

New Jersey's other large cities.

The introduction and widespread use of such techniques as radical surgical procedures, exchange transfusions, psycho-sedatives, and antibiotics have reduced morbidity and mortality in our very young and in our elderly population. In fact, mortality is now at its lowest point. In 1950, the death rate for those under five years of age was 80 per 1,000; in 1960, it was 20 per 1,000. This is a dramatic drop and a clear indicator of the advances in medical skill. The lowered death rate has been accompanied by a rise in handicapping conditions among the survivors. In addition to an obvious increase in our healthy population, medical technology has increased the longevity of our less viable populations, who often require support from our welfare, treatment and custodial services.

Another important factor, more complex and difficult to account for than simple population mix, in terms of impact, is the proportion of population increase due to net migration. It has been estimated that 48 percent of New Jersey's population increase between 1950 and 1960 was a consequence of in-migration and 50 percent of the increase between the years 1960-65 is attributable to in-migration. Although there is no readily available breakdown of the social characteristics of the in-migrant group, it is generally recognized (with ample data to support the contention) that large numbers of low income groups have poured into our cities primarily from southern states in quest of fresh opportunities. A second aspect of the in-migration factor seems important. Those coming into New Jersey have been young, increasing the potential birth rate, or have been ac-

companied by young children.

We have recited some of the factors contributing to the "dependency status" that characterizes large numbers of persons who potentially may receive all or part of their hospital care without any or only partial reimbursement to the hospital providing the service. The number of persons in New Jersey who fall into this category is suggested, although not fully identified, by an examination of the number of individuals in the caseloads of the various Federally-aided categorical programs and combining these with recipients of general assistance. The number of individuals in the caseloads of the various Federally-aided categorical programs for the month of June, 1967 was as follows:

OAA	14,615*
DA	9,513
ADC	135,025
AB	911
MAA	7,681*
	167,745

The Division of Welfare estimates that unduplicated persons in these categories in the State of New Jersey during a year exceeds 200,000. Children who are wards of the Bureau of Children's Services are not included because, like persons in the OAA and MAA categories, they are covered by hospitalization insurance. To complete the picture of persons who receive public assistance, individuals receiving aid from municipal assistance must be included. During the month of June, 1967, 33,692 individuals received assistance from those municipalities whose public assistance program received

* Hospitals who provide service to individuals in these two programs receive full reimbursement for the reasonable cost of providing such services.

support from the Division of Welfare. Since not all municipalities participate in this program, the Division of Welfare estimates that this figure would be increased by at least 10 percent or approximately 3,700 persons to include all the persons receiving general assistance during the month of June, 1967.

What does it cost to provide hospital services to these individuals? Unfortunately, there is no simple or easy answer to this question. In an effort to arrive at some estimate of this cost, the New Jersey Hospital Association made a study of the cost of indigent care in the State's non-profit private hospitals for the year ending December 31, 1965. A questionnaire was prepared by the Association and sent to general hospitals included in its membership. Although 94 hospitals with a bed capacity of 20,295 received the questionnaire, useable replies were received from only 33 hospitals with a bed capacity of 7,887.

The following table summarizes the region's hospitals contacted and useable replies.

Region	Questionnaires Mailed		Replies Received	
	Number of Hospitals	Bed Capacity	Number of Hospitals	Bed Capacity
1. Bergen County	8	1,527	2	592
2. Passaic and Morris Counties	8	1,750	7	1,678
3. Union and Essex Counties	23	5,629	6	1,574
4. Sussex, Morris and Somerset Counties	8	1,213	2	424
5. Hudson County	7	1,501	1	347
6. Hunterdon County	2	351	1	132
7. Middlesex, Union and Somerset Counties	7	2,082	4	1,055
8. Ocean and Monmouth Counties	6	1,365	3	630
9. Mercer County	5	1,241	2	605
10. Burlington, Camden, Atlantic and Gloucester Counties	11	2,312	3	563
11. Atlantic and Cape May Counties	4	712	-	-
12. Cumberland and Salem Counties	5	612	2	287
Total	94	20,295	33	7,887

These replies were analyzed by a group of New York Certified Accountants, who were employed by the New Jersey Hospital Association, to prepare a report from this data for their consideration. This firm reviewed the figures submitted for completeness and credibility. The total indigent inpatient cost reported by each hospital was checked by multiplying the reported indigent inpatient days by the hospitals' 1965 Blue Cross per diem rate.

For purposes of the Hospital Association study and the conclusions from it summarized in this report, it is important to note that the term "indigent care" is defined as that pertaining to persons who have been served under a formal federal, state, or municipal program providing for financial assistance to persons found, after investigation, to have insufficient income and resources for their maintenance needs. Consequently, it does not take into account the costs attributable to an even larger group of "medically indigent" persons who are cared for by hospitals without charge or at a reduced charge under a broad community service concept. No effort was made to include this latter group, because to have done so would have required relying on the judgment of each individual hospital and consequently the study would not have had an acknowledged common base. The cost of providing care for the group--"indigent care" --included in the study as well as projections for the hospitals not reported in the study is summarized in the table below.

	Hospitals Reported	Projection for Hospitals not Reported	Total
Bed Capacity	7,887	12,408	20,295
Inpatient - Cost of Care	$9,160,762	$9,473,222	$18,633,984
Received for this care	4,155,840	4,701,987	8,857,827
Unrecovered cost	5,004,922	4,771,235	9,776,157
Outpatient - Cost of Care	1,895,930	2,303,347	4,199,277
Received for this care	601,374	788,530	1,389,904
Unrecovered cost	1,294,556	1,514,817	2,809,373
Total Unrecovered Cost	6,299,478	6,286,052	12,585,530
Received Undesignated	793,786	1,304,272	2,098,058
Net Cost of Indigent Care	$5,505,692	$4,981,780	$10,487,472

The study also projected losses on indigent care, on an overall basis for the hospitals reported, without regard to the region in which the hospitals are located. When this technique is employed the projection of losses is summarized below.

	Hospitals Reported	Per Bed	Projection for Hospitals not Reported	Total
Bed Capacity	7,887		12,408	20,295
Inpatient - Cost of Care	$9,160,762	$1,161.50	$14,411,881	$23,572,643
Recovered for this care	4,155,840	526.92	6,538,001	10,693,841
Unrecovered cost	5,004,922	634.58	7,873,880	12,878,802
Outpatient - Cost of Care	1,895,930			
Recovered for this care	601,374			
Unrecovered cost	1,294,556		2,036,664	3,331,220
Total Unrecovered Cost	6,299,478	798.72	9,910,544	16,210,022
Received Undesignated	793,786		1,248,703	2,042,489
Net Cost of Indigent Care	$5,505,692	$ 698.08	$8,661,841	$14,167,533

When these statistics are related to individual hospitals, particularly those serving the so-called disadvantaged persons in our larger urban areas, the consequences are dramatic. It was reported

to this Commission that a sectarian hospital in one of the "core" cities in the metropolitan region of New Jersey annually provides services costing $1,600,000 to indigent persons. The hospital recaptures only $400,000 of this amount from county and municipal government. At the time the report was made to the commission, the reimbursement to the hospital was based on $12 per patient day rather than on its reasonable cost at that time of $41.80 per day. In addition, no provision was made to reimburse this hospital for the use of its emergency room facilities by large numbers of persons who received medical services from them.

In 1965 it was estimated that the welfare loss by four Mercer County hospitals amounted to $672,754. The County and eight of its municipalities contributed only enough to pay $18 a day for each indigent patient while the average cost to the three Trenton hospitals that provided the services was slightly in excess of $40 a day and $50 a day at the other participating hospital, Princeton. To make up this difference, hospitals must overcharge patients who do pay or accumulate deficits. This aspect of hospital financing, i.e., overcharge of those who pay, was referred to as collecting a sales tax on illness and injury by the Trenton Times staff writer, John Kolesar.

Problems associated with providing free hospital services to indigent persons have reached crisis proportions because of the constant increase in overall hospital costs. It was estimated that hospital costs in New Jersey increased five times as fast as the consumer index, and the cost of providing hospital care in the past decade has more than doubled. The average daily stay in a New Jersey hospital

cost just under $50 in 1966, as compared to $24 in 1956, while the cost of living overall rose 20 percent during this same period. The following tables dramatically illustrate the ever upward spiraling cost of providing hospital care for various regions in the United States for the selected years 1955, 1965 and 1967.

July 1953 Regional Hospital Business Report

REGION	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,412	3,345	8,858	1,066	2,947	7,782	1,750	3,674	8,081	1,216	3,612	9,332
% of OCCUPANCY	65.86	70.71	72.01	58.50	68.68	80.42	69.39	73.93	79.11	61.75	66.25	80.06
EXPENSES BY DEPTS.	Per Patient Day						Per Patient Day					
Administration	2.39	3.25	4.27	2.29	2.73	2.26	2.59	2.08	1.83	2.46	2.31	2.75
Dietary	3.63	3.69	4.34	2.86	3.07	3.26	3.04	2.71	2.78	2.67	2.66	2.75
Housekeeping	.98	1.55	1.89	.73	1.22	1.18	.91	.89	.80	1.05	.93	1.08
Laundry	.69	.74	.64	.53	.57	.55	.51	.41	.37	.57	.49	.35
Plant Operation	1.90	1.78	2.45	1.32	1.43	1.52	1.23	1.11	1.14	1.37	1.28	1.46
Medical & Surgical	.73	1.28	2.14	.76	1.07	1.24	.89	.97	1.58	.85	1.26	1.54
O. R. & Del. Rms.	1.24	1.43	1.96	1.10	1.24	1.23	1.32	1 37	1.18	1.28	1.51	1.75
Pharmacy	.86	.90	.93	.84	.80	.80	1.46	.88	.92	1.13	1.39	1.60
Nursing	6.31	6.15	6.47	6.20	6.02	5.11	5.47	4.89	4.74	4.68	4.92	4.79
Anesthesia	.67	.77	.88	.58	.55	.48	.56	.56	.59	.72	.67	.79
Laboratory	1.16	1.53	2.12	1.36	1.24	1.38	.97	1.45	.96	.98	1.31	1.46
X-ray	1.79	1.85	1.22	1.48	1.21	1.11	.89	1.21	1.02	.81	1.19	1.29
Other expenses	.14	.54	1.12	.15	.42	1.03	1.71	.48	.49	.34	.82	.82
TOTAL EXPENSES	32,181	86,732	278,726	21,352	64,100	170,250	36,413	70,094	150,368	23,104	75,299	211,850
TOTAL CHARGES TO PATIENTS	32,441	84,641	269,945	22,278	67,254	194,529	40,397	81,687	170,629	24,950	80,026	247,592
OPERATING INCOME PER PATIENT DAY	22.98	25.30	30.47	20.90	22.82	25.00	23.08	22.23	21.12	20.52	22.16	26.53
OPERATING EXPENSES PER PATIENT DAY	22.79	25.93	31.47	20.03	21.75	21.85	20.81	19.08	18.61	19.00	20.85	22.70

REGION	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. No. OF ADULT PATIENT DAYS	1,530	3,828	7,923	1,368	3,592	9,305	1,003	2,859	8,696	1,949	3,688	7,094
% of OCCUPANCY	78.57	92.07	79.66	67.88	75.46	66.53	56.32	64.55	85.26	73.26	70.56	78.05
EXPENSES BY DEPTS.	Per Patient Day						Per Patient Day					
Administration	2.02	2.37	3.57	2.23	2.43	2.76	3.19	2.70	2.45	3.46	4.50	4.38
Dietary	2.70	3.42	3.53	2.53	3.55	2.74	3.00	3.56	3.37	3.50	4.11	3.93
Housekeeping	1.01	1.01	1.56	1.01	1.33	1.04	1.02	1.12	1.16	1.26	1.74	1.58
Laundry	.51	.66	.58	.60	.58	.31	.89	.67	.56	.87	.87	.66
Plant Operation	1.35	1.48	1.80	1.38	1.45	1.78	1.78	1.39	.89	1.61	1.87	1.82
Medical & Surgical	.72	1.21	1.81	1.26	1.15	.84	.93	1.64	1.66	1.28	1.79	1.78
O. R. & Del. Rms.	.93	1.67	1.55	1.50	1.79	1.66	1.74	1.97	1.51	2.15	3.00	2.41
Pharmacy	1.37	.85	1.09	1.29	1.18	.95	2.17	1.33	1.26	1.48	1.21	1.16
Nursing	6.41	6.00	6.56	7.49	4.36	5.84	6.57	6.88	6.55	8.62	9.50	8.47
Anesthesia	.74	.57	.39	.08	.35	.73	.62	1.03	.16	.53	.53	.58
Laboratory	1.12	1.39	1.61	1.31	1.29	1.55	1.41	2.24	1.36	1.62	2.12	2.35
X-ray	1.59	1.47	1.26	1.35	1.03	.41	1.64	1.57	1.12	1.98	1.60	1.69
Other expenses	.29	.67	.99	1.14	.75	.50	2.52	.48	.33	1.16	1.24	1.55
TOTAL EXPENSES	31,412	88,474	216,387	29,114	77,738	199,737	26,493	77,540	199,658	56,668	125,521	230,541
TOTAL CHARGES TO PATIENTS	33,117	97,667	224,003	28,972	82,670	219,420	25,454	80,437	216,763	64,112	123,681	243,130
OPERATING INCOME PER PATIENT DAY	21.64	25.51	28.27	21.18	23.02	23.58	25.38	28.13	24.93	32.89	33.54	34.98
OPERATING EXPENSES PER PATIENT DAY	20.53	23.11	27.31	21.28	21.64	21.46	26.41	27.12	22.96	29.08	34.04	32.50

REGION	NEW ENGLAND Connecticut, Maine, Mass., N.H., R.I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N.C., S.C., Va., W.Va., D.C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AVERAGE NUMBER OF ADULT PATIENT DAYS	1,256	3,459	7,866	1,264	4,056	9,930	1,657	3,641	8,536	1,613	3,843	9,953
% of OCCUPANCY	64.08	81.86	83.94	71.02	80.00	83.54	77.03	76.20	81.69	73.48	76.75	84.91
EXPENSES BY DEPTS. Per Patient Day												
Administration	3.97	7.45	7.15	4.35	4.94	6.00	3.68	4.81	5.33	5.61	5.16	5.93
Dietary	4.16	5.01	5.48	3.90	4.23	4.59	3.37	3.96	3.90	3.79	3.44	3.79
Housekeeping	1.80	2.11	2.63	1.46	1.64	1.96	1.27	1.67	1.43	1.47	1.22	1.57
Laundry	.79	1.21	1.01	.85	.95	.96	.70	.95	.92	.81	.90	.83
Plant Operation	2.07	3.15	3.00	1.88	2.26	2.60	2.36	2.36	2.21	2.37	2.30	2.14
Medical & Surgical	1.18	1.93	3.46	1.49	2.16	3.57	1.34	1.90	2.50	2.65	1.79	2.43
O.R. & Del. Rms.	1.62	3.30	3.29	1.85	2.07	2.36	1.54	2.43	2.21	2.35	2.80	3.35
Pharmacy	1.17	1.71	2.15	1.62	1.88	1.62	1.77	1.92	1.88	2.52	2.29	2.56
Nursing	7.83	10.64	10.87	8.98	10.08	9.19	7.07	8.82	9.88	8.52	9.12	9.60
Anesthesia	.85	.65	1.53	1.04	.98	.90	.69	.97	.62	.70	1.30	1.08
Laboratory	2.95	3.74	4.98	2.72	3.45	3.44	1.71	3.17	3.31	3.43	3.62	3.63
X-ray	2.64	2.75	3.11	2.58	3.15	2.34	1.89	2.43	2.21	2.64	2.62	2.55
Other expenses	1.43	.95	2.46	.80	1.31	1.86	1.10	.85	1.63	1.82	1.03	2.34
TOTAL EXPENSES	39,960	158,290	414,179	41,820	160,114	423,859	46,456	133,127	328,815	60,403	142,315	423,130
TOTAL CHARGES TO PATIENTS	46,007	166,896	444,292	45,671	176,179	487,373	49,987	144,250	370,328	67,670	163,548	491,335
OPERATING INCOME PER PATIENT DAY	36.63	48.25	56.48	36.13	43.44	49.08	30.17	39.62	43.38	41.95	42.56	49.36
OPERATING EXPENSES PER PATIENT DAY	31.82	45.76	52.65	33.09	39.48	42.68	28.04	36.56	38.52	37.45	37.03	42.51

REGION	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N.D., S.D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N.M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AVERAGE NUMBER OF ADULT PATIENT DAYS	1,357	3,274	8,453	1,122	3,908	9,572	1,053	3,207	8,142	1,333	3,548	6,446
% of OCCUPANCY	72.96	78.83	84.04	63.52	77.78	81.48	60.52	73.80	77.16	65.47	68.84	65.00
EXPENSES BY DEPTS. Per Patient Day												
Administration	4.86	6.02	6.88	4.06	4.54	5.70	6.45	6.40	6.68	9.12	8.92	8.07
Dietary	4.07	4.18	4.94	3.47	4.15	4.01	4.39	4.34	4.91	5.52	5.83	5.63
Housekeeping	1.32	1.80	2.08	1.29	1.51	2.06	1.57	2.00	1.86	2.56	2.84	3.43
Laundry	1.03	.99	1.03	.82	.94	.82	1.17	1.48	1.08	1.68	1.57	1.32
Plant Operation	2.33	2.33	2.84	2.21	2.11	2.85	2.22	2.74	2.56	2.96	2.95	3.42
Medical & Surgical	2.14	2.31	2.61	1.93	4.18	2.56	1.86	2.95	3.83	1.41	5.79	7.86
O. R. & Del. Rms.	2.35	2.37	2.45	1.83	2.50	2.63	2.33	3.32	3.01	5.25	5.59	3.86
Pharmacy	1.62	1.82	1.52	1.41	1.65	1.99	2.28	2.31	2.16	3.01	2.48	2.49
Nursing	10.09	10.28	11.58	9.78	8.25	8.67	12.52	12.36	10.88	14.87	17.89	12.74
Anesthesia	.93	.81	.56	.61	.57	.66	1.06	.40	.30	.69	.58	.93
Laboratory	2.97	3.62	3.70	1.70	2.78	3.75	3.16	4.12	4.85	3.71	4.45	4.74
X-ray	2.72	2.78	3.12	1.85	2.32	2.55	2.96	2.52	2.84	3.21	3.41	3.62
Other expenses	.81	1.11	1.62	1.35	1.03	2.20	.50	3.23	2.72	2.36	1.44	2.77
TOTAL EXPENSES	48,539	130,906	383,226	34,241	143,340	391,362	44,595	151,285	391,051	72,306	215,852	396,037
TOTAL CHARGES TO PATIENTS	51,742	136,087	429,125	36,926	151,333	449,665	46,908	168,022	444,807	78,414	219,235	411,943
OPERATING INCOME PER PATIENT DAY	38.13	41.57	50.77	32.91	38.72	46.98	44.55	52.39	54.63	58.83	61.79	63.91
OPERATING EXPENSES PER PATIENT DAY	35.77	39.98	45.34	30.52	36.68	40.89	42.35	47.17	48.03	54.24	60.84	61.44

REGION	NEW ENGLAND Connecticut, Maine, Mass., N.H., R.I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N.C., S.C., Va., W.Va., D.C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AVERAGE NUMBER OF ADULT PATIENT DAYS	1,101	3,539	7,923	1,436	4,053	13,653	1,543	3,663	9,423	1,696	4,079	8,030
% of OCCUPANCY	60.17	79.04	82.76	72.26	78.69	85.28	75.04	76.98	80.18	67.18	75.92	78.12
EXPENSES BY DEPTS. Per Patient Day												
Administration	5.29	9.58	11.00	6.26	5.80	10.35	5.80	6.85	7.16	6.94	6.76	6.72
Dietary	5.09	5.58	6.28	4.97	4.62	5.58	3.79	4.45	4.43	4.50	4.17	4.72
Housekeeping	1.29	2.24	3.08	1.95	1.99	2.69	1.78	1.95	1.77	1.87	1.61	2.09
Laundry	1.00	1.64	1.47	1.15	1.13	1.30	1.01	1.23	1.09	.82	1.07	1.06
Plant Operation	1.94	3.52	3.42	2.47	2.11	3.55	2.39	2.86	2.25	2.35	2.60	2.45
Medical & Surgical	1.20	2.34	4.59	1.25	1.78	4.10	1.45	2.07	3.72	2.90	1.94	4.17
O.R. & Del. Rms.	1.53	3.62	3.94	3.16	2.89	3.20	2.48	3.13	3.10	2.45	3.20	3.26
Pharmacy	1.05	1.93	2.11	1.58	1.79	2.01	1.33	1.88	2.27	2.26	2.38	2.48
Nursing	10.07	14.14	15.21	11.65	13.98	14.80	10.76	12.18	13.32	12.78	11.74	11.84
Anesthesia	.23	.86	1.26	.74	1.15	.82	1.03	1.10	.69	1.29	.69	.66
Laboratory	1.57	4.85	6.21	4.19	3.58	4.68	2.22	3.59	4.24	2.85	3.26	4.17
X-ray	1.15	3.50	3.38	2.98	3.02	3.01	2.50	2.86	2.36	1.76	2.64	2.32
Other expenses	2.23	2.35	2.15	.65	2.88	3.65	.58	1.17	2.83	1.18	1.16	1.91
TOTAL EXPENSES	36,311	207,701	522,213	61,980	190,259	838,545	57,112	167,882	470,876	70,316	174,578	393,441
TOTAL CHARGES TO PATIENTS	39,652	225,959	554,239	65,416	214,015	915,906	58,996	191,659	529,250	71,723	197,360	461,766
OPERATING INCOME PER PATIENT DAY	36.01	63.85	69.95	45.55	52.80	67.08	38.23	52.32	56.17	42.29	48.38	57.15
OPERATING EXPENSES PER PATIENT DAY	32.98	58.69	65.91	43.16	46.94	61.42	37.01	45.83	49.97	41.46	42.80	48.69

REGION	EAST NORTH CENTRAL Illinois, Indiana, Michigan, Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn, Neb., N.D., S.D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N.M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AVERAGE NUMBER OF ADULT PATIENT DAYS	1,375	3,328	9,467	1,375	3,608	8,943	1,273	3,085	6,477	1,007	2,587	7,277
% of OCCUPANCY	69.59	75.40	85.63	72.44	72.97	81.75	68.64	68.30	67.04	55.65	66.43	72.29
EXPENSES BY DEPTS. Per Patient Day												
Administration	6.13	8.80	7.94	5.17	5.23	7.59	7.45	9.30	9.52	9.69	9.10	10.88
Dietary	4.51	4.81	5.32	3.57	4.13	4.71	4.48	4.76	5.35	3.83	5.19	5.54
Housekeeping	1.52	2.10	2.30	1.50	1.66	2.25	1.60	2.08	2.32	1.54	2.69	3.11
Laundry	1.14	1.27	1.23	.82	.98	1.10	1.22	1.66	1.52	1.15	1.94	1.36
Plant Operation	2.92	3.04	3.15	2.63	2.17	2.73	1.97	2.55	3.51	3.63	2.63	3.14
Medical & Surgical	2.91	2.78	4.25	1.70	3.39	2.78	2.34	2.45	2.16	4.58	3.26	10.18
O. R. & Del. Rms.	2.30	2.87	3.24	1.63	2.45	3.21	2.23	4.07	4.02	3.10	5.38	6.29
Pharmacy	1.67	1.92	1.92	1.44	2.06	2.23	2.11	3.05	3.06	2.69	2.56	2.76
Nursing	11.53	15.06	14.00	10.91	11.67	13.82	13.80	17.40	19.78	15.70	20.43	14.39
Anesthesia	.69	.76	.62	.82	.72	.75	.84	.51	.60	1.76	.51	.62
Laboratory	3.29	4.37	4.16	2.18	2.78	4.95	3.59	6.24	6.94	3.04	3.30	6.03
X-ray	2.35	3.09	2.46	2.18	1.56	2.14	2.52	3.49	2.53	2.33	2.29	4.87
Other expenses	.95	1.18	2.49	.83	1.32	2.37	1.75	2.65	3.62	1.06	2.03	5.88
TOTAL EXPENSES	56,778	173,334	502,068	47,163	145,175	460,150	58,030	185,684	421,045	53,635	158,649	551,729
TOTAL CHARGES TO PATIENTS	63,812	183,623	565,882	51,585	156,590	501,438	64,265	202,411	444,201	57,410	210,130	626,419
OPERATING INCOME PER PATIENT DAY	46.41	55.18	59.77	37.52	43.40	56.07	50.48	65.61	68.58	57.01	81.23	75.82
OPERATING EXPENSES PER PATIENT DAY	41.29	52.08	53.03	34.30	40.24	51.45	45.59	60.19	65.01	53.26	61.33	86.08

While net operating costs per patient day are highest on the Pacific coast, the New England and Middle Atlantic states follow close behind. Occupancy rates are higher in the Middle Atlantic states (72.44 - 81.75%) than on the Pacific coast (55.65 - 72.29%). However, in New Jersey, hospital costs approximate the national average. The New Jersey Hospital Association advised this Commission that, for the calendar year 1966, the national average cost per patient day in voluntary non-profit hospitals was $48.94, and for New Jersey it was $48.55.

The trends which have characterized operating expenses and operating deficits are dramatically illustrated in the following comparison of revenue and expenses in voluntary non-profit hospitals, 1960-1965. During this period the average hospital received less operating income than operating expenses. Solvency was maintained and the surplus achieved in five of the six years by income from sources other than patient-related charges.

Comparison of Revenue and Expenses
In Voluntary Nonprofit Hospitals, 1960-65

	Per Patient Day				
Year	Expense	Operating Revenue	Operating Deficit	Total Revenue	Net Surplus
1960	$31.16	$29.49	($1.67)	$31.79	$0.63
1961	33.23	31.51	(1.72)	34.16	0.93
1962	36.04	33.91	(2.13)	36.75	0.71
1963	37.77	34.91	(2.86)	37.74	(0.03)
1964	39.87	37.96	(1.91)	40.83	0.96
1965	42.47	40.40	(2.07)	43.28	0.81

Source: A.H.A. Guide Issues
Note: Total Revenue is equal to operating revenues from patient services plus all other revenues in accordance with A.H.A. Uniform Chart of Accounts.

Several factors seem most significantly related to increasing hospital costs. One such factor is the increased cost of capital construction.

The following table outlines the national experience in the cost of new general hospital construction.

S U M M A R Y

AVERAGE UNIT COST DATA

GENERAL HOSPITALS - NEW CONSTRUCTION

Year	No. Of Projects	Building & Fixed Equipment Per Sq. Ft. (Averages)	Building & Fixed Equipment Per Bed (Averages)	Project Cost Per Sq. Ft. (Averages)	Project Cost Per Bed (Averages)
1962	56	$24.95	$18,745	$29.42	$22,102
1963	67	26.51	20,622	31.48	24,476
1964	59	27.19	21,871	32.38	26,041
1965	49	29.06	25,684	33.82	29,886
1966	24	30.50	28,654	35.60	34,058

As the above table illustrates, construction costs for general hospitals nation-wide increased $10,000 per bed during the five year period 1962-66.

The Department of Health, Education and Welfare estimates a 13 percent increase in 1967 costs over 1966. Since these are national averages, the Commission asked the Department of Institutions and Agencies to prepare estimates of hospital construction costs for New Jersey. The New Jersey experience, as submitted by the Department, is as follows:

S U M M A R Y

AVERAGE UNIT COST DATA FOR NEW JERSEY

GENERAL HOSPITALS - NEW CONSTRUCTION

Year	Building and Fixed Equipment		Project Cost	
	Per Sq. Ft. (Averages)	Per Bed (Averages)	Per Sq. Ft. (Averages)	Per Bed (Averages)
1955	$20.00 Est.	$15,000 Est.	$24.00 Est.	$18,000 Est.
1962	26.02	19,482	30.51	22,837
1963	27.94	21,699	32.97	25,255
1964	29.CC	22,361	34.43	27,781
1965	33.17	24,160	38.63	28,953
1966	35.13	29,510	39.23	36,021

The New Jersey costs per bed during this period are approximately $1,000 higher than the national average. To secure a comparison the Commission requested an estimate for the year 1955. The Department estimated costs per square foot as approximately $20 and costs per bed at $15,000. This means that in a 12 year period the costs of construction of a hospital bed have almost doubled in New Jersey.

The following table compares selected growth factors, 1948-64, for the number of variables which have contributed to the increased capital construction costs.

COMPARISON OF SELECTED GROWTH FACTORS, 1948, 1964

Factor	1948	1964	Per Cent Change
Average Number of Beds per Project	43.21	101.00	+133.0%
Average Square Feet per Bed	598.53	804.00	34.3
Average Cost per Square Foot	$ 20.02	$ 32.38	61.7
Average Cost per Bed	$ 11,987	$ 26,041	117.0
Average Size of Project	$520,000	$2,600,000	500.0

Source: Public Health Service, Representative Construction Costs.

The financing of capital construction involves recourse to three major funding sources. Most non-profit voluntary hospital capital construction is funded not unlike the typical financing of a typical project outlined below.

TYPICAL FINANCING OF A TYPICAL PROJECT

Source of Funds	Per Cent of Total	Amount
Contributions	40.5%	$1,053,000
Public Funds	15.9	413,400
Generated by Hospital	43.6	1,133,600
	100.0%	$2,600,000

Source: Public Health Service

In order to finance capital construction projects, hospitals must of necessity secure long term loans. Accordingly, the increasing cost of borrowing money is a significant factor in hospital costs. The following table illustrates the method for calculating the costs of hospital indebtedness on a per bed basis.

HOW TO CALCULATE COSTS PER BED OF HOSPITAL INDEBTEDNESS

Assumed $2 Million Total Cost, of Which 50% ($1 million) Is Long-Term Debt Financing

Interest Rate (coupon at par)	Length of Loan (maturity in years)	Required Annual Payment for Principal and Interest (constant)	Cash payment on a per bed per day basis (292-day year assuming 80% occupancy) for various (1) interest rates, (2) maturities, and (3) construction costs					
			$15,000 per bed cost— 132 beds	$20,000 per bed cost— 100 beds	$25,000 per bed cost— 80 beds	$30,000 per bed cost— 66 beds	$35,000 per bed cost— 56 beds	$40,000 per bed cost— 50 beds
7 %	10 yrs.	$142,378	$3.70	$4.88	$6.09	$7.39	$8.75	$9.75
	20	94,393	2.45	3.23	4.04	4.90	5.78	6.42
	30	80,586	2.09	2.76	3.45	4.18	4.93	5.52
	40	75,009	1.95	2.57	3.22	3.89	4.08	5.14
6½%	10 yrs.	$139,105	$3.61	$4.76	$5.96	$7.22	$8.51	$9.53
	20	90,756	2.36	3.11	3.88	4.71	5.55	6.21
	30	76,577	1.98	4.63	3.28	3.48	4.68	5.22
	40	70,694	1.84	2.42	3.03	3.67	4.33	4.84
6 %	10 yrs.	$135,868	$3.53	$4.66	$5.81	$7.05	$8.31	$9.30
	20	87,185	2.06	2.98	3.73	4.52	5.33	5.97
	30	72,649	1.89	2.49	3.11	3.77	4.44	4.98
	40	66,462	1.72	2.78	2.85	3.45	4.07	4.55
5½%	10 yrs.	$132,668	$3.44	$4.54	$5.68	$6.89	$8.11	$9.08
	20	83,679	2.17	2.87	3.08	4.34	5.12	5.73
	30	68,805	1.79	2.35	2.94	2.57	4.21	4.72
	40	62,320	1.61	2.14	2.00	3.23	3.81	4.27
5 %	10 yrs.	$129,505	$3.36	$4.44	$5.54	$6.72	$7.92	$8.87
	20	80,243	2.08	2.75	3.44	4.17	4.90	5.50
	30	65,051	1.69	2.23	2.78	3.37	3.98	4.45
	40	58,278	1.51	1.99	2.50	3.03	3.57	3.94
4½%	10 yrs.	$126,379	$3.28	$4.33	$5.41	$6.56	$7.73	$8.65
	20	76,876	2.00	2.63	3.29	3.99	4.70	5.27
	30	61,392	1.59	2.10	2.63	3.18	3.75	4.20
	40	54,343	1.41	1.36	2.32	2.82	3.33	3.72
4 %	10 yrs.	$123,291	$3.20	$4.22	$5.28	$6.40	$7.54	$8.45
	20	73,582	1.91	2.52	3.15	3.82	4.00	5.04
	30	57,830	1.50	1.98	2.47	3.00	3.53	3.96
	40	50,523	1.31	1.73	2.17	2.62	3.09	3.46

Hospital expenses at operational levels are related primarily to two factors--increasing labor costs and increases in the ratio of employees to patients, although as a recent Department of Health, Education and Welfare study reflects, there are factors other than these. As summarized by William Gorham, Assistant Secretary for program coordination,

> "Certainly some part of the accelerated increase in hospital costs may be attributed to Medicare and to increases in the prices of the things hospitals

buy, including labor .....But the increase is also attributable to the rapidly increasing demand for hospital care, duplication of facilities, and lack of price competition among hospitals.....hospitals had too many highly trained people doing routine jobs and too many patients in the hospital who didn't have to be there."

While this Commission agrees that all these factors need consideration, since its primary focus was on the relationship between voluntary non-profit hospitals and indigent patients, it did not address major attention to them. This Commission, however, wishes to call attention to several of these factors.

Since payrolls constitute 70 percent of hospital operational costs, either increased compensation or increased employees will have a significant impact on overall hospital costs. Although hospitals have made dramatic strides in development and utilization of labor-saving devices, the demands of improved medical technology are such that during the period 1960-65 there has been an increase in the ratio of employees per patient from 2.27 employees per patient to 2.46 employees per patient. More important than the increase in employees has been the increase in rates of compensation for hospital employees. It was reported in 1951 that the minimum pay in the Trenton-Mercer hospitals was $.56 per hour. Between 1951 and 1962 the hospitals granted four pay increases to non-professional employees. During the period 1962-66 it granted an additional four increases with a minimum pay of $1.45 per hour. Professional personnel employed by hospitals

have also received pay increases and the tradition of "donated service" by hospital employees now seems passe.

The Commission would like to direct attention to a major point made by Mr. Gorham in his report on the preliminary findings of the Department of Health, Education and Welfare study which it believes to be of central importance to the problem it has considered.

As stated by Mr. Gorham:

> "We are close to saying people have a right to good medical care.....Poor people have been given a chit to buy medical care.....We are close to saying the charity hospital will have no place in the future, and there must not be two grades of medical care."

If fiscal relief, by way of government aid, is to be provided New Jersey's public and non-profit private hospitals for the care of indigent patients, only three alternatives suggest themselves:

1. County Boards of Freeholders and/or municipalities where these medical institutions are located can increase their lump sum grants to hospitals or revise their reimbursement formulas for payment for indigent persons who receive care from them. Since a number of New Jersey counties already make lump sum grants equal to the maximum which the law permits, statutory revision would be necessary if any of these counties indicated a wish to pursue this alternative.

2. The Department of Institutions and Agencies and the County Welfare Boards could expand their program of providing hospitalization insurance for persons served by federal categorical programs of public assistance. It was estimated two years ago by the Division of Welfare, Department of Institutions and Agencies, that to include all persons not otherwise covered by hospitalization insurance in the various federal categorical programs the cost to New Jersey would be approximately $11 million. If present formulas for providing for the non-federal portion of these costs were continued, State costs would be approximately $5.5 million with an equal cost to the counties. Since this estimate was made two years ago and hospitalization insurance has risen sharply since that time, this figure would necessarily be revised substantially upward by the Department's actuaries.

3. Substantial relief is available to public and non-profit private hospitals from another area--the implementation in New Jersey of a Title XIX program authorized by the 1965 amendments to the Social Security Act. Because of the complex character of such a program and the financial cost associated with it, this Commission devoted much of its time to discussion of issues related to the implementation of a Title XIX program in New Jersey.

The kind of State Medical Assistance Program for which Federal matching funds are authorized under Title XIX of the 1965 amendments to the Social Security Act is based on an extension to other age groups of the basic principles of the "Kerr-Mills" program of Medical Assistance for the Aged, authorized in 1960 and which has been in operation in New Jersey since 1963. Title XIX permits New Jersey to develop a comprehensive Medical Assistance Program in a series of four phases of coverage, leading to full coverage of the needy and medically needy population and to a full range and scope of services. It is mandatory, that in the first instance, a State must include medical assistance for all individuals and families otherwise receiving Federally-aided public assistance; (in the course of a year approximately 200,000 unduplicated individuals). This is the minimum coverage that must be provided by any State in order to have an approvable plan under Title XIX. In addition, the State has the option of providing medical assistance to individuals and families not actually receiving Federally-aided public assistance but who would be eligible, in terms of low income, insufficient resources, and categorical characteristics, if they chose to seek supplementary aid. The State also has a further option of providing medical assistance to groups of otherwise non-dependent persons who would be eligible for categorical public assistance except for the fact that their income and resources are in excess of New Jersey's standard for maintenance assistance. If the State includes any of these medically-dependent, it must include all medically needy who are blind, disabled, aged, or in families with dependent children. Put another way, if

the State pays for medical care for elderly persons over sixty-five who are self-supporting except for medical care, the State also must pay for medical care for medically needy blind and disabled persons and for medically needy children and adults in families who would qualify for the basic assistance programs if their incomes were low enough.

States have an additional option of phasing toward progressive implementation under Title XIX by choosing to provide full and comprehensive medical care for all medically needy children under age twenty-one even if they are ineligible for assistance under the Aid to Families with Dependent Children program. This refers to families in which the parent or parents might be employed full time yet not earn enough to meet medical costs and, therefore, qualify for such aid for their children.

The present law requires that by July 1, 1975, participating states' Title XIX programs must include substantially all of the foregoing groups and, in addition, all the State's medically needy who do not come within these special group definitions.

New Jersey can move by four stages, or fewer, to assure a broad spectrum of medical care for persons who need it but cannot afford it. The first step must include all people who depend on the federally-aided public assistance programs for all or some of their basic maintenance. This must be done by January 1, 1970, if New Jersey is to continue to receive federal sharing in the medical care components of its existing programs. New Jersey may additionally,

at any time between now and 1975, include (1) those who are "categorically related"; that is, who meet the income requirements for financial assistance for daily maintenance but do not in fact receive it, and (2) the "medically indigent"; that is, those who need assistance with medical payments only. If these provisions are not adopted in the initial Title XIX coverage the State must demonstrate reasonable progress toward meeting them by the July 1, 1975, deadline.

It is the basic principle of this Medical Assistance program that the income an individual or family needs to use for basic support other than medical care must be protected for such use. However, the legislation requires each State to set its own level of income or resources needed for basic maintenance and this level must be comparable for all groups included in the State's program. Persons whose income and resources are below this level and who are otherwise eligible must, therefore, be included in the State's Title XIX program. Although the Federal law provides considerable latitude to the State, this level cannot be lower than the level of maintenance now in effect for the most liberal of the State's money-payment maintenance programs. For instance, in New Jersey the current standards relevant to this requirement are exemplified in the following illustrations: For a single aged individual, living alone, the prescribed normal maintenance budget, exclusive of medical care, is $150 per month, or $1,800 per year. For a representative family of four (this being the Federal "statistical family" of two adults and two children, one being a teen-ager) the prescribed normal maintenance budget, exclusive of medical care, is $330 per month, or $3960 per year.

The Federal law also sets further limitations on the kinds of eligibility tests the State may impose. Only available income and resources may be considered, and if the income is not certain or irregular, only that income which is actually in hand may be counted. If income is in excess of the amount set by the State for ordinary living expenses, the amount in excess must first be applied in a way to enable the person to pay for any medical care or services which are not within the scope of the State's medical assistance program. For example, if dental care and eyeglasses are not included in the State's program, any excess income must be reserved for those services before it may be considered as available to the client to permit him to contribute toward the cost of the kind of services which are included within the State's program.

Title XIX also provides another important change from New Jersey's present Kerr-Mills program. The State, for purposes of the Medical Assistance program, can no longer hold adult children responsible for the medical expenses of their aged parents. The Federal legislation permits the State to consider a spouse responsible for a spouse and parents responsible for children under twenty-one or children of any age if they are blind or disabled, but no other "relative" responsibility may be legally imposed.

Also, as in Kerr-Mills, the State may not impose a durational residence requirement as a condition of eligibility for Medical Assistance. Consequently, under a Title XIX program the State must find eligible all otherwise eligible persons who are residents of the State, without regard to the length of the residence. The State must also make arrangements to provide medical assistance to residents

of the State who are temporarily absent from it.

In the scope of the medical care to be provided, the Federal law now requires that any State's Title XIX program must provide as an absolute minimum the following five services:

1. Inpatient hospital services (which must be reimbursed to the hospitals on the basis of reasonable cost);
2. Outpatient hospital services;
3. Physicians' services (whether furnished in the office, the patient's home, a hospital, a nursing home, or elsewhere);
4. Skilled nursing home services for persons over 21; and
5. Laboratory and x-ray services.

The statute prohibits mere token offering of these five basic services, and it lists the following additional classes of medical service which the State must ultimately include within its program, and which may be immediately included, with Federal sharing, if the State so elects:

6. Any remedial or medical care furnished by practitioners licensed in the State;
7. Home health services;
8. Private duty nursing;
9. Clinic services;
10. Dental services;
11. Physical therapy and related services;
12. Prescribed drugs, dentures, prosthetic devices, and eyeglasses;

13. Other diagnostic, screening, preventive and rehabilitative services; and

14. Hospital and nursing home services for individuals aged 65 and over in institutions for mental disease and tuberculosis.*

Another important requirement for a Title XIX program is that the State, for its aged assistance recipients, must pay the deductible portion of the medical costs under the Hospital Insurance for the Aged, commonly called Medicare. In addition, the State may pay these deductibles for medically needy old people who are otherwise unable to pay them. The State may also pay the co-insurance costs of the Hospital Insurance Plan but such optional payments for aged persons may be made under the Title XIX program only if services of the same duration are also furnished under Title XIX to all other eligible persons. Title XIX

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*The Department of Institutions and Agencies, Division of Public Welfare, has already established a Bureau of Institutional Services to secure the additional Federal fiscal support of patient care in mental and tubercular hospitals which was authorized under these amendments. Federal aid in the care of these patients is anticipated by the Department at an annual rate of $6 million. An important by-product of this program has been increased staff which is available to deal with the social problems of the aged in the hospitals and the attitudes of their families in the community. The Department anticipates expanding this program in 1968 to include selected patients who may be moved from within the institutions for mental disease and mental retardation into alternate care arrangements in the community.

also permits payment of the deductibles and co-insurance of the Supplementary Medical Insurance, also known as Part B of Medicare, but as in the case of co-insurance under Part A of Medicare, payment of such costs for aged persons is possible only when equivalent services are provided under Title XIX to otherwise eligible individuals.

Another extremely important feature of this legislation is that for the first time in the history of Federal Social Security, Congress has prohibited States from using Federal funds as a substitute for State money. This feature, known as the requirement for "Maintenance of State fiscal effort," means that the State participating in the Medical Assistance program must continue to spend at least as much State money for public assistance as it did before. Consequently, portions of State money "released" by the availability of increased Federal matching funds under Title XIX must be used to broaden and liberalize the State's public assistance programs by at least an amount equal to the Federal increase in funds.

The Title XIX legislation also includes important provisions centered around the concept of equal treatment. Except for the specific exclusion of persons under 65 who are in mental or tuberculosis hospitals, all medical services offered by the State's program must be equal in amount, duration and scope for all beneficiary groups included in the program. Thus, service made available to one group of the needy must be the same for all the other categories. The State may, however, provide services for all persons who are "medically needy"

only, which are of lesser amount, duration and scope than those provided for all persons receiving public assistance for maintenance.

To summarize, if New Jersey is to continue to receive Federal aid for public assistance medical care after 1969, we must create a single Medical Assistance program, and if such program is not comprehensive in coverage and content initially, we must extend and improve it both by specific statutory provisions and by administrative requirements. In this, time is a crucial factor.

By January 1, 1970, New Jersey must have a separate Medical Assistance program under Title XIX or else be prepared to finance without federal matching any vendor payments for medical care made on behalf of recipients of assistance.

Also by July 1, 1970, the non-Federal share of the cost of a Medical Assistance program must be financed entirely from State funds and not involve any requirements for a share to be borne by "local" funds unless safeguards are included in the law and operating procedures to assure that a scarcity of local tax funds does not impede the program's operation.

House Bill, H.R. 12080, which is being considered by the Federal Congress at the time this report was completed, proposed changes in a number of the provisions of the Act covering Social Security rates and payments, the Medicare and Medicaid programs, public assistance programs, child welfare and health care for mothers and children. Of specific interest to this Commission are the proposed limitations of the income level set by a State to define the "medically needy". The House set the ceiling at 133 1/3 percent of the highest amount

ordinarily paid to a family under this particular State's AFDC program or 133 1/3 percent of the State's average per capita income, whichever might be lower. The Senate version of the Bill sets this ceiling at 150 percent of the amount paid under the State's OAA program.

The House provision of this Bill provides that states may offer a Medicaid program that would include any seven of the 14 services, rather than the basic five services required under the existing law. The Senate version requires the five basic services for all money payment recipients, but permits the "7 of 14" choice for the medically indigent.

As of the writing of this report, the House and Senate had not reconciled their differences and consequently we cannot predict how the final amendments, if any, may affect the basic 1965 amendments to the Social Security Act.

As all the above suggests, these amendments are extremely complicated and require a careful and deliberate approach. Fortunately, the Division of Welfare, the Department of Institutions and Agencies and its Board of Public Welfare have given long serious consideration to problems relating to the implementation of a Title XIX program in the New Jersey. The Division of Public Welfare made studies of costs relating to the implementation of a Title XIX program as it relates to the number of persons to be covered and scope of services to be provided.

These original estimates were made available to this Commission and the Commission reviewed them with officials of the Department

of Institutions and Agencies. The Department agreed to make its study available to Prudential Life Insurance Company and Blue Cross, the Hospital Service Plan of New Jersey. This was done with a request by this Commission that actuaries of Prudential and Blue Cross review the Department's study both as regards its methodology and its conclusions. The actuaries of these two companies subsequently presented a combined report which, in general, approved the methodology employed by the Department, but differed with the fiscal conclusions. The Department, thereafter, forwarded both the original study and the conclusions of Prudential and the Hospital Service Plan of New Jersey to the Federal Department of Health, Education and Welfare, with the request that the Department of Health, Education and Welfare scrutinize the available data and provide the Department with any information relevant to the differing estimates of costs. The conclusions of the Department of Health, Education and Welfare, tabulated in comparison with the earlier estimates by the Department of Institutions and Agencies, and Blue Cross-Prudential respectively, are as follows:

FIRST YEAR COST* OF TITLE XIX PROGRAM IN NEW JERSEY
Comparative Estimates by Source of Estimates

Source of Estimate	Date Prepared	Assumed Population Cohorts Low (1)	Intermediate (2)	High (3)
Division of Public Welfare	November 1966	$151,064,915	$177,325,896	$212,074,030
Department of Health, Education and Welfare	October 1967	$170,912,885	203,856,494	241,075,368
Prudential - Blue Cross	June 1967	215,000,000	**	**

* Estimates shown in this tabulation do not include costs of administration. The Division of Public Welfare suggests that such costs should be estimated at 15% of the amounts shown.

**Data not provided (continued)

Notes Related to Comparative Cost Estimates:

(1) Relates to approximately 13% of State population, at income levels below ceilings of $1,600 for single person and $3,100 for family of four;

(2) Relates to approximately 16% of State population, at income levels below ceilings of $1,800 for single person and $3,600 for family of four;

(3) Relates to approximately 20% of State population, at income levels below ceilings of $2,000 for single person and $4,000 for family of four.

Problems encountered by states which have implemented a Title XIX program are well known to most readers and little purpose will be served by this Commission enumerating them in detail. For purposes of this Commission it is sufficient to point out that most of these problems have their origin in program elements of a Title XIX program other than the reasonable reimbursement of hospitals for care of indigent patients. However, since this Commission is concerned with the fiscal problems of hospitals that may be traceable to care furnished to persons generally referred to as "medically indigent", we do feel responsible to point out to the persons and agencies who will be concerned with formulating the dimensions of this group, the dangers inherent in establishing definitions that are not compatible with the economy of the State.

This Commission has given careful consideration to this most controversial aspect of a Title XIX program--the definition of "medical indigency". The Commission was fortunate in having close liaison with New Jersey's Board of Public Welfare and wishes to call attention to the important contributions by this group of distinguished,

non-salaried citizens who have given long and careful consideration to problems relating to the implementation of Title XIX. It is their responsibility to recommend, through the Division of Public Welfare, to the State Board of Control guidelines to be considered in developing a Title XIX program for this State.

This Commission was fortunate to have available as a resource person Director Irving J. Engelman, Division of Public Welfare, of the Department of Institutions and Agencies. He functioned as a liason person between this Commission and the Board of Public Welfare. Mr. Engelman reported to this Commission that the Board of Public Welfare has formulated a definition of "medical indigent" to be recommended for consideration by the State Board of Control, substantially as follows:

> That individuals and families with income and resources in amounts greater than would permit them to qualify to receive aid under the public assistance programs should be regarded as "medically indigent," when, in the course of any three-month period, expenditures incurred by them for medical services shall have reduced their remaining income and resources to a point below the public assistance level of eligibility.

This Commission believes that this thoughtful recommendation can serve as a point around which an intelligent dialogue of this most significant issue in the implementation of a Title XIX program can commence.

CONCLUSION

In the light of all of these considerations, the Commission has concluded that the most desirable solution to the problems of hospital financing, which were the Commission's direct concern, will be found in the enactment of a Title XIX program, to become effective January 1, 1970, or earlier if fiscally and administratively feasible. Such a Title XIX program should, with specific relation to hospital services, include the elements recited below.

RECOMMENDED ELEMENTS OF A TITLE XIX PROGRAM

RELEVANT TO HOSPITALIZATION

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1. It shall guarantee, to all licensed hospitals in New Jersey, a source of prompt payment of full reasonable cost of inpatient service furnished to those individuals, residents of New Jersey, referred to in 5 below.
2. It shall guarantee, to all licensed hospitals in New Jersey, a source of prompt payment of full reasonable cost of outpatient clinic services and home health services furnished to those individuals, residents of New Jersey referred to in 5 below.
3. It shall guarantee, to all licensed hospitals in New Jersey, a source of ultimate payment of amounts, otherwise uncollected, representing reasonable costs of both inpatient and outpatient services furnished under emergency circumstances to persons not residents of New Jersey.
4. It shall guarantee, to all professional practitioners providing services in the hospitals, who are not otherwise paid by the hospital, a source of payment of reasonable charges for such services.
5. The guarantees of payment referred to shall relate to those persons who:

   a. At the time of receipt of hospital services are active recipients of financial assistance from any State, county

or municipal welfare, health, or rehabilitation department in New Jersey, or

b. Following initiation of hospital service, are determined to be in such financial circumstances that they would have been eligible to receive public assistance, as in (a), if a prior application had been made, or

c. After initiation of service, and in any event within a reasonable time not more than three months subsequent to the termination of hospital service, are determined to be "medically indigent."

6. An appropriate State agency (which may be but need not be the administering agency) shall be charged with the duty of establishing, and revising from time to time as economic circumstances require, standards and criteria for determining "medical indigency".