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

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

To examine policy issues relating to the financing of hospital uncompensated care

July 21, 1988
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Chairman
Assemblyman Rodney P. Frelinghuysen
Assemblyman George J. Otlowski

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and Human Resources Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
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New Jersey State Legislature
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June 16, 1988

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE
ANNOUNCES A PUBLIC HEARING
TO EXAMINE POLICY ISSUES RELATING TO
THE FINANCING OF HOSPITAL UNCOMPENSATED CARE

Thursday, July 21, 1988
Beginning at 1:00 P.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Thursday, July 21, 1988, beginning at 1:00 P.M., in Room 341 of the State House Annex, Trenton, New Jersey, to examine current and proposed policies for the financing of uncompensated care provided by acute care hospitals in this State, including any related legislation that may be pending before the committee at that time. The committee intends to hear testimony from individuals, agencies and organizations for the purpose of obtaining information and considering policy options to ensure an appropriate and equitable method of financing hospital care for the medically indigent.

Address any questions or requests to testify to David Price, Committee Aide (609-292-1646), State House Annex, Trenton, New Jersey 08625. Those wishing to testify are asked to submit nine 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.

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ASSEMBLYMAN HAROLD L. COLBURN (Chairman): I'm going to open the public hearing on uncompensated hospital care. The purpose of this get-together is to try to identify problems and possible solutions.

Of course, I tried to help precipitate interest in this by introducing a bill. I think it generated some interest. (laughter) It's not necessarily the final solution, but I really had hoped to hear more from the Commission studying this problem by this point. I realize in Trenton things don't happen on time, even the beginning of my public hearing, but we're trying to get closer to the mark. The current legislation expires at the end of this year, and we hope not to do something in haste towards the end. So perhaps by what you tell us today, and other things that we hear -- as we keep the record open for at least 30 days -- we'll be able to judge better what the potential solutions to this problem are.

I don't know anybody who doesn't want to provide care to people who need care, whether they can pay or not. Of course the question is, how do you do it, and who is supposed to pay the bill? I'm not completely satisfied with my own bill last term, which was, of course, Senator Codey's bill before mine. But it did accomplish the job, and that was good.

I'd like to introduce Assemblyman Frelinghuysen, John Kohler -- a staff member -- David Price, Assemblyman Otlowski, and Miss Morrison -- Messinger. I have a little Freudian slip there because she's really on the other side. A very good staff member. We have wonderful people not only on the Committee but on our staff. David is the nonpartisan staff member.

I'd like to call first, Commissioner Coye, who we appreciate the presence of, and please tell us what you would like to about this subject.

C O M M I S S I O N E R M O L L Y J O E L C O Y E: Thank you very much, and good afternoon. I'm here today with Christine Grant, who is my Deputy Commissioner with responsibility primarily in the area of uncompensated care, the subject we are discussing today. I hope to be joined soon by Special Deputy David Knowlton, who is responsible for rate setting and licensure-- (inaudible) --hospitals. I hope that with that I will signal to you the importance of the topic to us that you have called the hearing on today. I appreciate the opportunity to speak to you today.

As you know, the State of New Jersey has reimbursed hospitals for their uncompensated care since 1979. So, we're coming up on a decade of experience in this area. Although the process has been modified over the nine-year span, there have been several fundamental keystones of our system which have remained constant. Do you need another copy? (referring to prepared statement)

ASSEMBLYMAN COLBURN: I'm looking to find mine. Okay. Excuse me. I like to follow these things.

COMMISSIONER COYE: Okay. And I will follow the text really closely. I was going to begin by summarizing the three fundamental keystones of our system, which have remained constant since we began in 1979.

The first is access to care: Access to care, in talking practical terms, means that when you are sick and need hospital care you can go to any hospital in the State and receive care, regardless of whether you can pay for that care, and more specifically, whether you have health insurance. In our system, all the residents of New Jersey who need hospital care, but can't afford the cost, can get it.

The success of this program has been confirmed. We don't see reports in our newspapers -- as we see in many other states -- of patients being dumped, or of hospitals refusing to treat or admit patients because they can't pay for their care.

Our success has also been confirmed by the Robert Wood Johnson Foundation, which found that residents of New Jersey had better access to health care than those from other states. Our minority groups did particularly well, compared to the problems they've had in the rest of the country with access to care.

The second keystone is full reimbursement. Full reimbursement in New Jersey means that hospitals which provide care to people in need are guaranteed that they will be paid in full for the services that they provide. This eliminates the incentive for hospitals to dump patients, and it allows our acute care hospitals to remain in good financial health. This is happening while hospitals across the country have closed their doors, or sent the uninsured away without needed care. Our system allows hospitals to bill and collect 100% of their costs, and pays them as much for their uninsured patients as for those who are insured.

The third keystone is equity among payers. What this means is we spread the cost of uncompensated care across the broadest possible base. Our system maintains balance among those who pay for care, and these costs must be reviewed and approved by the Rate Setting Commission, so that there is a strenuous and vigorous review of costs that come before the Commission.

In New Jersey these costs -- the cost of uncompensated care -- are borne by 89% of the population; New Jerseyans who do have health insurance. This is a very broad base. And because of such a broad base, we minimize the costs of paying uncompensated care costs for any one individual. It's spread across a very broad base of the population.

Why do we need an uncompensated care system at all? We need it because so many people in our society still don't have health insurance. This is the root problem. Over 15% of U.S. citizens have no health insurance. Most of those people are employed people or their dependents. They are people who

work in small businesses, or are self-employed and can't afford the costs of health insurance, or they are the uncovered dependents of workers who do have insurance, or they are people who fall just above the Medicaid income threshold and don't have the financial resources to buy health insurance. They also include now the unemployed.

All told nationally, people who don't have health insurance constitute 37 million people. In New Jersey we do better than the rest of the country as a whole. Only about 11% of our population is uninsured, approximately 843,000. We still have 11% that are not insured, however, despite the extremely low unemployment rate that we have in the State and the very healthy economy that we've enjoyed for the last few years.

In the past, it used to be that if you were employed you could be reasonably certain that you would have good health care coverage as a part of your employment. Because the structure of the economy has been changing, more and more people are employed in New Jersey but don't have health insurance as a benefit of their employment. As a matter of fact, 45% of the uninsured are people who are employed, a further 30% are their spouses and children -- in other words, dependents of people who are employed. So the vast bulk of the people who are uninsured in this State are employed or their dependents.

When you passed the Uncompensated Care Trust Fund legislation two years ago, you, the Legislature, mandated that we look for alternative mechanisms to fund and provide uncompensated care. We have done that. Two years ago, I assembled a broad-based Steering Committee on Health Care for the Uninsured, including representatives from business, governmental agencies, health insurance, the hospital industry, and consumers, in order to help me and my staff evaluate our system and give us advice on how to improve our system.

As part of the Trust Fund legislation passed 18 months ago, you also established the Trust Fund Advisory Committee, which included more specifically representatives from the New Jersey Business and Industry Association, the Chamber of Commerce, Blue Cross, commercial insurance companies, the Hospital Association, consumers, members of the Legislature -- a member of that Trust Fund Advisory Committee, Assemblyman Frelinghuysen has been a very active member of the committee, from your Committee here -- representatives of the executive office, and of other State agencies, in order to make recommendations to me on the future of the Trust Fund. We have consulted with national experts to get their advice on what policy options we can explore. We have met with key interest groups in New Jersey, and we have extensively reviewed all of this material in order to prepare a report which will summarize what we have learned from this, and what the options recommended by the Trust Fund Advisory Committee will be.

There is a remarkable consensus among the groups I have just mentioned to you who serve on the Advisory Committee about the next steps concerning the Trust Fund.

For those of you who don't know him, I'm glad to introduce David Knowlton, who is the Deputy in charge of regulatory affairs.

These are the steps that the Advisory Committee agreed on, that we wholeheartedly support, and around which there is very wide consensus in most of the other sectors that we discussed this with:

1) The Trust Fund should continue.

2) Hospitals should continue to receive full reimbursement for uncompensated care that they provide.

3) The rate setting system should remain intact in order to keep costs from continuing to rise more than necessary.

4) Stringent audit and cost control measurers do exist now. They need to continue to be strengthened. We have recently taken some action before the HCAD -- Health Care Administration Board -- in order to make them more stringent, to make sure that which we are reimbursing as uncompensated care costs, are, in fact, appropriately reported.

5) The local medical assistance and county welfare programs should be challenged to optimize the number of people eligible for Medicaid and General Assistance, since that takes people off the uncompensated care roles.

6) Lastly, our solution lies in trying to get more people into health insurance. What that means is to make affordable insurance available, particularly to small employers where the largest percentage of the working uninsured are found.

In addition, I strongly support the concept of Assembly Bill 3179, sponsored by Assemblyman Frelinghuysen, which would require college students to have health insurance. It is through these and other such mandates that lifelong patterns of purchasing health coverage can occur.

We should be proud that in establishing the Trust Fund, we have taken a significant step towards solving a problem that nationally is a deepening crisis. We are the only State that currently has a truly effective and successful system for assuring payment for care provided to the uninsured.

Currently, we finance this cost through add-ons to hospital rates, as you know. This is paid with increases in health insurance premiums. And as you know Medicare will now no longer pay their share of uncompensated care. So the amount of this add-on has increased in the past, and will increase again in 1989.

But for those of who are following my testimony, to return to a point I made at the bottom of the previous page, we are all in agreement that New Jersey should continue to pay for uncompensated care. The question of how uncompensated care

should be financed is what we're here to talk about today. So when I say that there was agreement that the Trust Fund be continued, everyone agreed that the Trust Fund mechanism as a way of making sure that uncompensated care is reimbursed should continue. And that the issue before us all is the issue of financing of the Trust Fund.

There are three broad possibilities for financing uncompensated care. First, that the entire amount should be raised through hospital rates, the way we do today; second, that only a portion should come through the rates and the remainder should come from other sources; and third, the entire amount should come from sources other than hospital rates.

Assembly Bill 3476, which was recently introduced to address the funding for uncompensated care for 1989 to 1990, causes me great concern. This bill would violate all the keystones of our approach to uncompensated care. It would give hospitals an incentive to dump uninsured patients; it would leave many hospitals in a financial lurch with threatened bankruptcy; and it would make the system dependent upon a fundamentally unstable source of funding, general revenues.

As you are aware, hospitals in New Jersey are required by law to be paid in full for services that are rendered to patients, regardless of that patient's ability to pay for the care received. I strongly support imposing rigorous billing and collection procedures to ensure that hospitals collect as much of a bill as a patient can pay. Last week, I just mentioned, we did propose to the Health Care Administration Board for final adoption -- and they adopted -- a set of regulations to tighten our controls over this area. This is necessary to make sure that hospitals don't write off patient bills as uncompensated care, without strenuous efforts to collect from people who could pay.

But Assembly Bill 3476 would substantially reduce payment to hospitals below what it costs to provide the care. This is not good business practice, and it is not good health policy. It will create a downward spiral of payment below true costs that even the best managed hospital will not be able to recover from. Ultimately it will keep people who need hospital care from receiving it, and it will impact negatively on the quality of care that everybody else in the hospital has as well.

A suggestion -- which I'm sure some of you are aware of -- has been advanced by the New Jersey Business and Industry Association: to use a mechanism similar to the Unemployment Trust Fund to finance uncompensated care. This approach would take some or all of the costs of uncompensated care out of hospital rates and thus either totally or substantially reduce the add-on. A benefit of this approach is that would proportionately distribute the cost of uncompensated care among all of those who pay Unemployment Insurance, not just employers who provide health insurance benefits to their employees as our current system does. My staff is currently exploring this option and when, and if, it continues to show promise, we will discuss the proposal with the Trust Fund Advisory Committee and with you.

Whatever mechanism we select in the future, however, it is imperative that together we find a way to continue the Trust Fund through new legislation. If we are unable to achieve this, we will be forced, by law, to revert to the system that was in place prior to the enactment of the Trust Fund. That approach caused significant problems which made it necessary to create the trust fund mechanism to begin with. Under the old system, each hospital had its own uncompensated care add-on. This meant that a hospital that had substantial uncompensated care had a high add-on, and therefore higher bills for patients with insurance.

If this is allowed to happen again, the hospitals which we most rely upon to provide care to those in need would be the very hospitals that would be most drastically affected. Insurers would avoid them because their costs for uncompensated care would be higher than other hospitals. These same hospitals would soon be forced to close down -- as we've seen in other parts of the country -- or, as in the past, be bailed out by special funding from the Legislature on an unpredictable and sporadic basis. We will not be able to ignore these cries for help, nor would you even consider it when they arrive on your doorstep in the Legislature. No one wants this situation, especially because it would remove one of the major benefits of our current system; that is, the ability of hospitals and the State to conduct solid financial planning for each year in advance.

Right now, all New Jerseyans have access to hospital care. All hospitals receive full reimbursement. Everyone shares equally in the system. We don't want this to change.

We have welcomed your cooperation in working on this issue, and the cooperation of the Hospital Association, and most importantly, the payers that pay the bills for uncompensated care. I look forward to working with all of you to continue to try to ensure access to care for everybody in our system.

I appreciate very much the work we have been able to accomplish together in the past, and I look forward to working with you in trying to solve this over the next couple of months.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen, do you have some questions or a question?

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman. I'd just like to say for the record that I have been serving on the Uncompensated Care Trust Fund Advisory Committee. I should also say for the record that I'm on the board of a hospital, one of those that is part of the system. Part from that latter

perspective, I'm acutely aware that the system that is in place is delicately balanced. And I must say that the legislation that has been introduced in no way desires to dismantle the system. I am aware of the Commissioner's rightful concern about that prospect. But I think it's fair to say that the bill, as Chairman Colburn described it, is a real attempt to be of assistance to the Uncompensated Care Trust Fund Advisory Committee; to really get us to address the problem on a timely basis. I have no desire to dismantle a system which I think I've got a better knowledge of than when I originally started on the Committee, thanks to Chris' work and Mrs. Powers, and other members of the Committee.

I think, as you said in your statement, Commissioner, what we're really here to talk about, and to use your words on page five-- The question of how uncompensated care is financed is what we are here to talk about. As far as I'm concerned, we're not here to dismantle a program that has worked effectively, and all components of which appear to be generally in agreement is working well.

I think we really want to focus maybe on this whole question of the add-on. You mentioned in your statement that Assembly Bill 3476 does cause you concern. Why is the add-on question -- the seven percent that's proposed-- The bill limits the uncompensated care add-on to hospital bills to seven percent. Why does a movement in reduction to either seven percent, or let's say to nine percent, endanger the entire balance that I referred to earlier?

COMMISSIONER COYE: I think in the concept as it was introduced in the bill, the purpose of both the cap of the seven percent and providing the power of the Rate Setting Commission to reduce by three percent the full reimbursement to the hospitals for uncompensated care, were both intended to limit how much monies would come from the Trust Fund to hospitals for uncompensated care, and also to limit the amount

of money that would be needed there for the Trust Fund. I don't know to what extent it was fully understood that what that would mean is that the burden would be shifted back onto the hospitals that provide the uncompensated care, because under Chapter 83 their rates would have to unequally go up, because under our system we are mandated to pay their full bills -- under Chapter 83 -- so they would not receive the money. What would happen is their bills would, under our old system, go back up disproportionately. If I'm being unclear please interrupt me.

ASSEMBLYMAN COLBURN: No.

COMMISSIONER COYE: Okay. So that the hospitals that provide -- and there are probably 15 or 20 hospitals that have a significant burden in this regard, in a system of 30 hospitals approximately that draw down from the Trust Fund, and they need money from the Trust Fund -- these hospitals would begin the downward spiral I was talking about because the paying patients, or the insurer, would tend to withdraw their patients from those hospitals. Their proportion of uncompensated care would go higher and higher. Their bills will go higher and higher.

Ultimately, whether it's because of what might have been intended, in a sense to actually reduce their reimbursement immediately -- which I don't think would be achieved by this bill because of the redistributive mechanism that exists in the law -- or because it's two years down the line and all this is played out, what you will have is a smaller number of hospitals with a very large uncompensated care burden, which will become like some of our worst nightmares, like exist in other states, of under-funded public or not for profit private hospitals -- often religious institutions, Catholic; Jewish, and other religious institutions -- that will not turn someone away, no matter what. Those hospitals are going to be in very severe situations.

That's exactly what New Jersey has been able to avoid, and what we're very proud of about the New Jersey system. We would far rather continue -- at the prodding of the Legislature, and in response to our own concerns -- continue to make this a very stringent system, and look for stable sources of funding that do not mean that hospitals receive less than full reimbursement.

The part of this bill that I want to emphasize today that I am most concerned about is the part that suggests less than full reimbursement to the hospitals. I'm sorry to take so much time.

ASSEMBLYMAN FRELINGHUYSEN: No. I thank you.

ASSEMBLYMAN COLBURN: No. We want to go into the thing thoroughly. Something else?

ASSEMBLYMAN FRELINGHUYSEN: I must say, Mr. Chairman, during the course of the meetings that have been held on uncompensated care, the public session, I have mentioned from time to time that I do think that many New Jerseyans, if they knew of the present system, would give it high respect. It's complicated. It's well balanced.

The argument has been made that the costs ought to be shared more evenly by all taxpayers, not just those who have health insurance. Can you just sort of address that, philosophically? I have made suggestions -- and I'm sure they haven't found very enthusiastic ears in the executive branch, the Governor's office -- that New Jersey taxpayers ought to be willing, as they do to pay for food, shelter and clothing for people who don't have it, to really bear, themselves, in an even-handed way the costs of hospital care.

COMMISSIONER COYE: Right. Actually, I have to say I always learn something from each time I go through the process of preparing, but until you spoke now I didn't realize-- You raised a very interesting question. I don't know -- and perhaps someone on the Committee does -- what proportion of New

Jerseyans don't pay taxes, because their income is very low, or very any other reason? Eighty-nine percent of the people in New Jersey contribute to this system because they have health insurance, and all of them, whenever they go to the hospital, their bills are paid for by the health insurance system. So if 89% of the people in the State are supporting this system and contributing to it, how does that compare to general revenues as a base? I would suppose that we may be coming very close to including the same number of people. It looks like-- (inaudible)

ASSEMBLYMAN FRELINGHUYSEN: Some groups are obviously paying a greater proportion of that 89% than others. I think that's perhaps some of the rationale behind the language in our bill. It's not evenly distributed among those who provide health insurance for their employees.

COMMISSIONER COYE: That's true. And I think that's where the BIA's suggestion comes from -- the idea that employers who don't provide health insurance ought to be carrying some more of this load. I'm not sure that the redistribution by going to general revenues would be as effective in terms of getting the responsibility on the direct party, but this is something, as I suggested, we're only exploring at this point. I think all of these points are open for discussion. I am most directly concerned about the limitation of reimbursement. And I do hope that you will understand that 89% -- even though your point is well taken -- is broader, I think, than most people understand. They think that it means that only those people who go to the hospital are paying for this system and it's described as a tax on sick people. But it's not a tax on sick people because everybody who has insurance -- even if you don't go to the hospital for 10 years -- is contributing to this. So at least that distinction, I think, is important.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: This is costing us, what, now?

COMMISSIONER COYE: Our current total in the State for uncompensated care in 1988 is 450.

ASSEMBLYMAN OTLOWSKI: And what kind of money do you say that you need?

COMMISSIONER COYE: We expect that this will continue to go up unless the national trends on insurance change. The total sum that we would estimate for 1989 -- as a very rough guess at this-- I think we're talking roughly about 490.

ASSEMBLYMAN OTLOWSKI: You're talking 90 million?

COMMISSIONER COYE: No, 490 I said.

ASSEMBLYMAN OTLOWSKI: No. It's costing you 400 million now.

COMMISSIONER COYE: Four hundred fifty million.

ASSEMBLYMAN OTLOWSKI: How much?

COMMISSIONER COYE: Four hundred fifty million this year.

ASSEMBLYMAN OTLOWSKI: It's costing you 450 now?

COMMISSIONER COYE: Yes.

ASSEMBLYMAN OTLOWSKI: And what do you project it will cost you, say, in the next two years?

COMMISSIONER COYE: If we add up this year and next year together?

ASSEMBLYMAN OTLOWSKI: Yes.

COMMISSIONER COYE: We're probably talking about somewhere between 900 million, close to a billion. (inaudible) Per year? Oh I thought it meant the two years added together. I'm sorry.

ASSEMBLYMAN OTLOWSKI: Let me rephrase the question. You're spending 450 million now. What would it cost you next year? What would it cost you in the next year? How much additional money do you need?

COMMISSIONER COYE: Somewhere between 450 and 490. Part of what we don't know depends on the Rate Setting Commission on some of the-- (inaudible)

ASSEMBLYMAN OTLOWSKI: Do I understand you correctly? Are you saying it's going to cost you a billion dollars?

COMMISSIONER COYE: Not per year. I thought you were asking for a two-year total.

ASSEMBLYMAN OTLOWSKI: In two years?

COMMISSIONER COYE: I think it would be important to point out that in the State of Pennsylvania for example--

ASSEMBLYMAN OTLOWSKI: No, no. Let me just get something clear in my-- The 450 million that you're spending now, you have no problem? You are meeting that cost?

COMMISSIONER COYE: Yes.

ASSEMBLYMAN OTLOWSKI: But next year you're going to have a shortfall?

ASSEMBLYMAN COLBURN: No, they'll raise the surcharge.

COMMISSIONER COYE: Oh okay-- (inaudible)

ASSEMBLYMAN OTLOWSKI: You're supposed to raise the--

COMMISSIONER COYE: (consults with staff) Maybe 40 to 50 million more.

ASSEMBLYMAN OTLOWSKI: So about 50 million more?

COMMISSIONER COYE: Yes.

ASSEMBLYMAN OTLOWSKI: And you would get that 50 million, how?

COMMISSIONER COYE: Under our current system, if we continue that--

ASSEMBLYMAN OTLOWSKI: By increasing the surcharge?

COMMISSIONER COYE: Increasing the surcharge, yes.

ASSEMBLYMAN OTLOWSKI: Under your current system, are there any other proposals that are in the frying pan that could cook?

COMMISSIONER COYE: There's, I think, two proposals that have been made that are really significant. The current bill that's been introduced proposes that general revenue should make up that difference, actually should pay more of it because it would cut back the seven percent that--

ASSEMBLYMAN. OTLOWSKI: Yes, but I think that Assemblyman Frelinghuysen said you'd probably have trouble getting any additional money from general revenues, if I understood him correctly.

ASSEMBLYMAN COLBURN: Plenty of trouble. (laughter)

ASSEMBLYMAN OTLOWSKI: So really your only realistic source would be in the surcharge. Is that correct?

COMMISSIONER COYE: Either the surcharge or this idea that the Business and Industry Association has just introduced, which is the idea that if the UI Trust Fund is protected for the unemployment insurance-- In other words, if the advisory committee right now that labor and industry are on comes up with a protection, that it might be possible to use that same mechanism to raise all or part of the money.

ASSEMBLYMAN OTLOWSKI: Would the fund be able to withstand the impact of that kind of an increase, of that kind of a surcharge?

COMMISSIONER COYE: We don't know the answer to that yet, and that's why we said we're just exploring it. We will come back to you with information with that when we have an answer. I wouldn't venture a guess right now. Technically it can do it. Whether people would want to do it, is a question we don't know yet.

ASSEMBLYMAN OTLOWSKI: But you're exploring that possibility?

COMMISSIONER COYE: Yes.

ASSEMBLYMAN OTLOWSKI: Are you satisfied with-- I noticed in your testimony you're talking about auditing and then you're talking about improving it. How would you improve it? You haven't determined how you would improve your auditing process?

COMMISSIONER COYE: Oh, we've not only figured out some of the improvements that we would want to make, we've already made some of them. But if we keep working with big

eight accounting firms to ask them to look at our system to come up with ideas on how we can strengthen it and improve it-- So for example, the proposals that we just put in to the Health Care Administration Board increase the frequency and the number of charts that get audited, so that we're becoming more stringent. Those things we came up with ourselves. But we want to continue to work with accounting firms and other groups in the insurance industry and others, because there may be even other improvements we can make to sort of hold the hospitals' feet to the fire and make sure that everything possible is being done to collect the money.

ASSEMBLYMAN OTLOWSKI: Let's assume that you improved your auditing methods. Would that mean anything to you money-wise?

COMMISSIONER COYE: Ultimately, like two or three years from now, it might mean several tens of millions at the very maximum. Right now I don't think we have a good way to estimate. I mean, it's pretty hard to pick a number out of the air. When you do these, some of these things don't pan out to make any difference, and some of them may.

ASSEMBLYMAN OTLOWSKI: You also said that you wanted to tighten your controls on billing procedures. How would you do that?

COMMISSIONER COYE: That's along the same lines that we are now-- We've already put in a proposal that doesn't give the hospital as much time. I don't remember how long, but we used to give them a very long period of time. Now we're tightening it up in the number of months they have to do their billing and make their report to us.

ASSEMBLYMAN OTLOWSKI: Do you have the capability at the present time to track your billing procedures, to make sure that they're working to capacity?

COMMISSIONER COYE: Chris, you may want to comment on that?

DEPUTY COMM. CHRISTINE M. GRANT: We have had an audit team for several years. I think we feel that we can continue to improve that audit team, not only by frequency but the kinds of questions asked, the way samples are taken from bills, questions asked to make sure that eligibility determinations are made. It requires additional effort, but the additional cost of audit relative to the yield we feel would be-- (inaudible)

ASSEMBLYMAN OTLOWSKI: But no matter how good you get internally, you're going to need money. No matter how good you get, you're going to need additional money.

DEPUTY COMMISSIONER GRANT: Right.

ASSEMBLYMAN OTLOWSKI: No matter how good you get, you're going to need additional money. Let's assume that you get real good, you could still need, what? You're talking probably 40 million more?

DEPUTY COMMISSIONER GRANT: Yes.

COMMISSIONER COYE: There is no doubt-- Nationally the number of people who are uninsured is going up, hospital costs are going up. Between those two things, it's inconceivable, no matter how tightly we monitor the system, that this is not going to continue to be a rising cost. I don't want to put a false face on this. We are-- (inaudible)

ASSEMBLYMAN OTLOWSKI: Thank you very much.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen, I think you had another question. Did you?

ASSEMBLYMAN FRELINGHUYSEN: What does the Department do? Does the Department require hospitals to collect uncompensated care fees for services before they're written off as bad debt?

COMMISSIONER COYE: This is an area where I think Chris has got, as you know, more expertise.

DEPUTY COMMISSIONER GRANT: I don't quite understand the question, the uncompensated care fee?

ASSEMBLYMAN FRELINGHUYSEN: How do we classify things as bad debt? What efforts are utilized to collect from those who have provided services before it goes off into a bad debt category.

DEPUTY COMMISSIONER GRANT: Okay, fine. It's a fairly detailed set of procedures. Very simply, the first step is to determine if the person is a medically indigent, very low income person, at which become point they become a charity patient. Most people are not, so at that point they are liable for their bills. They will be sent their bills. There are several bills that must be sent. The hospital is not committed to write up any bill where there is a reasonable chance of collecting. If they don't collect, they routinely would send it to a collection agency. That collection agency must hold onto that for a certain period of time. Then ultimately there are dates specified in regulation. At that point, hospitals may write off yet unpaid amounts. They must still try to collect parts of bills, if not all of the bills. They are required under certain circumstances to take people not only through collection, but to the court to get their bills paid.

ASSEMBLYMAN FRELINGHUYSEN: When we met in our committee, there was some statement by a representative from the Hospital Association that they didn't have the computer capacity to track some of these costs, and some of those who in fact make up the largest portion of indigent costs within the system.

DEPUTY COMMISSIONER GRANT: I personally wouldn't find that an acceptable answer. I don't remember hearing that exactly. I know that we have a--

ASSEMBLYMAN FRELINGHUYSEN: It had something to do with computer capacity, the ability to--

DEPUTY COMMISSIONER GRANT: I know that in the outpatient area, where you have 12 million visitors statewide, that there is a particular issue related to the yield, if you

have a $50 bill, how much you pay to collect. But we have taken a position as a Department that that's not necessarily a good reason, that if people have several $50 bills over a period of time there should be a system to track them and collect it. I don't think the regs would permit hospitals to use that as an acceptable excuse in writing off the bills.

COMMISSIONER COYE: If I could make another comment. I think there's no doubt that you will have here heard, and will hear again, individual anecdotes of people who are rather wealthy and go to hospital and have their care written off as uncompensated care. That kind of thing happens in any system, in the best system that can be put together. What I weigh that against, as we do continue to become more stringent in the way we monitor this, is the fact that don't hear anecdotes and reports of people who are being turned away for care. I think it's sort of a question of which kind of anecdotes are you going to run the risk of in trying to tighten down your system to make sure it doesn't happen? But I certainly do want to say up-front that I would be surprised if you don't hear occasionally some anecdotes, and when they're reported to us we always try to follow-up on those, because frequently it will reveal to us some problem in the system that we can do something about.

ASSEMBLYMAN FRELINGHUYSEN: Okay. Thank you.

ASSEMBLYMAN COLBURN: Thank you. One of the things that I wondered was whether we could get some figures about what one percent of the surcharge would equal in dollars collected, to put into the funds for the years '87, '88, and projected for '89; so we know what seven percent means as compared to the 490 million, and what eight percent, nine percent, ten percent would equal as a share of that Trust Fund? Then I was wondering if we could find out what one percent of a DRG reduction would mean to a hospital. I guess it would mean different things to different hospitals. So we

could take some representative ones, maybe the ones with the largest DRG -- or rather the largest need to take out of the Trust Fund, for '87, '88, and '89.

Now, I assume that the surcharge itself would yield more dollars next year than it would last year, because the DRG rates have gone up a little bit. But then of course that would be offset by the need of the hospital for a higher reimbursement. But I just would like to get some ideas about how those things would shift around.

Another thing I wondered was, in collecting money from people who aren't paying who we thing might be able to pay, do we go after any wages or their homestead rebates, or maybe, I don't know, income tax returns, or anything like that?

COMMISSIONER COYE: Chris informs me that the system doesn't provide for anything like that now.

ASSEMBLYMAN COLBURN: Doesn't do that now?

COMMISSIONER COYE: I think that we certainly are very open. I think Assemblyman Frelinghuysen would reflect also, that on this issue of audits that we are very open to suggestions on that. And again, part of the reason we went to the big eight firms is to talk with them about these issues. I think that applying, sort of sound business practices to some of this may yield us some better answers on how to approach it. So we would be glad to work with your staff, Assemblyman Colburn, on trying to look at which of these could be implemented.

ASSEMBLYMAN COLBURN: Okay.

ASSEMBLYMAN OTLOWSKI: Doctor, if I could just follow up the question that you asked?

ASSEMBLYMAN COLBURN: Yes, Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: The question that the doctor is raising, you know, when you're going after the unpaid bill, and you discover that there's money there but the person is still not paying his bill, what mechanism do you put into effect? Do

you go after him by way of getting a judgment so that you can execute on the judgment?

COMMISSIONER COYE: Yeah, the hospital is responsible for doing that, but there is clear responsibility in our law that they do not get reimbursed by us, that they are responsible for ultimately taking that person to court if they have to.

ASSEMBLYMAN OTLOWSKI: It's the hospital's responsibility?

COMMISSIONER COYE: To collect. And the lever we have is that we won't pay them unless they carry out their responsibility. In other words, they don't have the option of deciding they don't feel like taking this person to court and writing it off, because in our auditing of their-- Now, one time it might pass through, but in our auditing we do pick up if there is a pattern of abuse of that type.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you. I just wanted to follow that up.

ASSEMBLYMAN COLBURN: Yes. Well, thank you. Do we have any knowledge of court cases that have had to do with this?

COMMISSIONER COYE: We have to survey the hospitals.

ASSEMBLYMAN COLBURN: We'll ask the hospitals that when they come in. But I guess that's something that your organization should know.

COMMISSIONER COYE: Actually, I am reminded, our Supreme Court just had a ruling on a case of a North Jersey hospital which had cared for what turned out to be an indigent prisoner. The issue there was the hospital's requirement under the law. Ultimately the county was found to have liability--

ASSEMBLYMAN COLBURN: So the county had to pay?

COMMISSIONER COYE: --through the term of incarceration. That's certainly one court case where that hospital worked very hard and took it to the Supreme Court.

ASSEMBLYMAN COLBURN: I'm not too anxious to put more burdens on the county government, but when I was a freeholder, when we found that there was this add-on within our system to take care of indigent care, the county dropped its appropriation for indigent care. And I think at the time we, the Burlington County Freeholders, saved something over $300,000 that we would have given to the principal local hospital that provide that care. So I don't know whether now we should start to look again to counties or not. We're trying to think of everything here. That's what we're trying to do.

COMMISSIONER COYE: Well there's no question that over the last 10 years or so, or 15 years, there's been a marked dimunition in previous county contributions to a lot of these expenses. That again gets into an area that is not usually our area of expertise, as far as understanding the local or county finance issues, vis-a-vis the State.

ASSEMBLYMAN COLBURN: No, no.

COMMISSIONER COYE: Our main concern -- and let me sort of leave this as a strong message -- is that it be a stable funding base, that both general revenues at the State level and the county and local may have problems in how regularly -- especially in lean years -- the monies flow to the hospitals. Given that uncompensated care is high in exactly those areas that are having the most problems fiscally, unless this is set up in a way that that's a first penny off the dollar that goes to the hospital, I would be very worried about the stability of that funding. That would be my concern.

ASSEMBLYMAN COLBURN: I know how you feel, because we've discussed this. But you know, it really troubles me that we have a stable funding source that comes from a floating surcharge. You know? Here we have a surcharge that we're putting on folks, and the State government itself isn't willing to put their own money in there. I mean, it just goes against my grain somehow. I don't know what is. It's probably a Pavlovian response on my part.

COMMISSIONER COYE: Well, the only thing I can say is that we are paying as a State about 10% of the bill; that Medicaid pays 20% of the bill, and half of that is from the State.

ASSEMBLYMAN COLBURN: True.

COMMISSIONER COYE: So we are paying 10% of the bill. Now I don't know how one comes to the conclusion of whether that's the fair share or the amount that the State should pay--

ASSEMBLYMAN COLBURN: Okay, well that's--

ASSEMBLYMAN FRELINGHUYSEN: We're looking for more Medicaid options, Mr. Chairman.

ASSEMBLYMAN COLBURN: Well, I understood that the folks in the other branch of the government weren't anxious to have more Medicaid folks eligibility. Is that--

ASSEMBLYMAN FRELINGHUYSEN: The Department of Human Services?

ASSEMBLYMAN COLBURN: I don't know where they are, but they're somewhere in that other branch. (laughter)

COMMISSIONER COYE: The one thing that I can fairly point out on this is that, obviously as someone in public health, my ultimate goal is I would like everybody in society to have health insurance.

ASSEMBLYMAN COLBURN: Sure.

COMMISSIONER COYE: So I don't want to appear to be arguing against health insurance as an approach, but it is much more expensive to insure an individual than to pay for uncompensated care. That's basically the difference we're talking about here.

ASSEMBLYMAN COLBURN: Because you're including a lot more, is that it?

COMMISSIONER COYE: Yes. For each person you put on the Medicaid roles, you're spending a lot more than you would be if you only paid for their care when they went to a hospital.

ASSEMBLYMAN COLBURN: Just plugging it into this. Okay. Well, that's a point.

COMMISSIONER COYE: I instituted the Health Start Program because I wanted very much to make sure that there was a health insurance approach for that population that's highly at risk, but there are trade-offs to be made.

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman?

ASSEMBLYMAN COLBURN: Yes?

ASSEMBLYMAN FRELINGHUYSEN: The Commissioner describes her desire to keep it stable. Of course it's stable inasmuch as it does represent sort of a hidden-- It is somewhat hidden that there are benefits obviously by as complicated and as delicately balanced system that we have -- and God bless that we have it. We have inner city hospitals that are able to keep their doors open, provide access to the needy. But I must say, the thing that galls some of us is the fact that there appears to be a hidden tax, with the probability of it being raised to 12%, 13%, 14%, or 15%, what we know to be an add-on. Many taxpayers, even those that are in the 89%, that contribute, are totally unaware that this is something that they're so generously contributing when they enter the hospital or when they pay their health insurance -- or when their corporation pays it for them -- to provide really for such a stable system as we have.

COMMISSIONER COYE: But one thing. If you compare us to other states, it's interesting to realize that for those hospitals that do manage to stay afloat providing uncompensated care in other states, the way they do it is by shifting those costs to the privately insured patients in their hospital, because cost shifting is allowed in those states where it isn't here. So it's a hidden tax in other states too. Basically, society seems to be willing to pay for this if they don't have to actually realize they're spending the dollars. They think everybody should have the access to the care, and they're willing to pay for it in this way. And almost no State has been willing to, out of general revenues, fund full expenses.

What you wind up with is this sort of inner city, very sad, basically horror stories, in terms of hospitals that are under-funded and can't provide quality care. And that's what I'm afraid that we may provoke.

ASSEMBLYMAN COLBURN: Thanks. I really appreciate all the time you've spent. I don't know whether your staff folks can stay, but we'll let you leave because I know you have other places to go.

COMMISSIONER COYE: Thank you.

ASSEMBLYMAN COLBURN: Thank you very much. Mr. Scibetta, do you want to bring your forces to the table here? I didn't say "horses." I said, "forces." (laughter) Good afternoon.

L O U I S P. S C I B E T T A: Good afternoon, Mr. Chairman. I'm Louis Scibetta, President of the New Jersey Hospital Association. With me is Craig Becker, who is the Vice President and Director of Government Relations and Regulatory Affairs.

I'm speaking as the chief executive officer of the New Jersey Hospital Association that represents all hospitals in the State of New Jersey. But also I'd like to point out that I'm speaking as a small businessman who employees about 250 people, and as such, all of whom need and receive health care services in the State of New Jersey. From that point of view, we believe that the uncompensated care system -- as an employer and as a member of the New Jersey Business and Industry Association -- the present system is very fair and very equitable and serves us well.

We appreciate very much the Hospital Association's opportunity to address two critical issues:

One is, how do we continue to guarantee that the ever increasing amount of uncompensated care provided by acute care hospitals are reimbursed to the degree that those hospitals can remain in operation?

And second, can we continue to rightfully boast of New Jersey's unique approach to handling uncompensated care wherein patient access to care is assured, regardless of that patient's ability to pay?

Uncompensated care applies to all parts of New Jersey, and I would hasten to point that out. It includes urban areas, suburban areas, and it includes rural areas. Wherever poor industrial areas are, and wherever poor rural farm workers are, that's where uncompensated care is. It is just as necessary in Bridgeton, New Jersey, as it is part of our more urbanized city areas.

Two years ago I testified before this same august Committee, supporting the creation of what since has become known as an innovative and nationally acclaimed Uncompensated Care Trust Fund. The fund has successfully spread the cost of indigent care among the 93 acute care hospitals in the State, while demonstrating a public and private sector responsibility to our poor people and to those who do not pay their bills.

Unlike some states where the practice of indigent patient dumping -- as mentioned by the Commissioner of Health -- from one hospital to another has been graphically documented, New Jersey has had a proud tradition of caring for those who cannot pay for hospital care. The mechanics of this equitable disbursement of funds, combined with the very fact that the law which gave birth to our DRG system, discourages dumping by essentially guaranteeing full payment, have yielded a legacy of caring.

But now, on a variety of fronts -- perhaps most directly in the shape of Assembly Bill 3476 -- the full funding of uncompensated care, at least on its surface, appears to be in jeopardy, at a time especially when the hospitals as an industry can least afford any further financial drain on an already very fragile reimbursement system.

I was very pleased to hear Commissioner Coye's support of the Advisory Committee's recommendation that hospitals receive full reimbursement for uncompensated care.

This bill in question would essentially cause insolvency, and accordingly, it would directly affront the mandate of Chapter 83, which requires that our hospitals be maintained as solvent in their operations through the rate setting system.

No doubt you have heard the hospital industry's arguments during the last year regarding the under-funding of our regulated reimbursement system. Media reports have trumpeted severe shortages of health care workers and the high cost of new technologies, caring for AIDS patients, protecting our health care workers from the AIDS virus, and removing and disposing of hospital waste.

Despite those fiscal challenges, New Jersey hospital charges still remain among the lowest in the country. Since I last appeared before you, the Equicor Corporation -- a conglomerate of a for profit hospital company located in the south, and an independent insurance company -- shows that New Jersey, with a daily patient charge of $476, ranked 49th lowest in a nationwide comparison of 1987 hospital charges in this nation. The fact that New Jersey hospitals can keep its hospital consumer costs so low while still managing to care for its indigent patients is a remarkable accomplishment.

But we now face a time of delicate balance in the health care industry. It is our contention that any of the proposals brought before you today that would delete dollars from our already bare-bone reimbursement system would simply rub salt into the wound. With all due respect, Mr. Chairman, Mr. Frelinghuysen, Mr. Otlowski, the proposals in A-3476 to cap uncompensated care at seven percent; to deduct three percent from revenues exceeding the cap; and to require hospitals to accept the Medicaid rate in all emergency room situations will

drain what we would classify as the lifeblood out of the Uncompensated Care Trust Fund.

The result? Such provisions would only serve to put many of our higher uncompensated care hospitals into bankruptcy. Hospital executives will simply have to turn the keys of these buildings over to the State, while some of our hospitals would be put in a position where they would have to limit access to health care. I would submit that neither of these alternatives is acceptable to the hospital industry or to the public, and certainly, we know, not to this Committee. The New Jersey Hospital Association, therefore, must go on record as categorically rejecting such an approach, and therefore indicating that we would vigorously oppose this legislation in its current form.

Dr. Uwe Reinhardt, who is probably well known to each of you as a world authority on health care finances, associated with Woodrow Wilson, and Professor of Economics at Princeton University, has described the uncompensated care system in New Jersey as one that classifies New Jersey among the few civilized states in this country.

Instead of considering a change in our system that would deny access to our hospitals by the poor and needy, we would suggest strongly that you look to alternative funding sources, if that seems appropriate, to help keep the existing Uncompensated Care Trust Fund operative. The existing fund is a unique and sound approach to sharing the burden of uncompensated care. It has proven itself to be a good system for government, good for business, good for hospitals, and perhaps most importantly -- certainly to you -- it's good for the public.

One possible approach to keeping the fund liquid would be to accept the recommendation of the Governor's Uncompensated Care Trust Fund Advisory Committee, either develop a new tax to fuel the fund, or redirect an old. I would say

parenthetically, that hearing the comments of Commissioner Coye relative to utilizing the State Unemployment Insurance Fund as a mechanism to fund the uncompensated care program, would certainly be acceptable to the hospital industry. This is, it would seem on the surface at least, appears to be an existing tax which everybody in this room certainly concerned ourselves with. The 93,000 employees in the hospital industry would be concerned about maintaining the solvency under any circumstances, as you would be. But on the surface it would appear to be a very viable, fair, and reasonable approach. I will listen with interest to the Business and Industry's recitation as to the potential efficacy of that approach.

Clearly, a broad-based tax would be carefully structured and possibly directed at those businesses that do not already provide health care insurance to employees.

In addition to supporting the development of broader-based funding sources for the Uncompensated Care Trust Fund, I'd like to make one other important point.

I've heard, and the Commissioner addressed -- and you asked the questions, and I believe you'll probably hear again today -- what I would classify as unsubstantiated and preposterous claims that hospitals aren't doing a good job of collecting their bills, hence contributing to the overall high uncompensated care price tag. It is my observation -- my personal observation -- that if I receive any criticism along those lines, it's been because hospitals are so diligent that they are collecting their bills from their hospital patients. Those are good business practices, and they meet good business standards. Certainly no business in this State can say that no situation falls between the cracks, and I wouldn't begin to claim that for the hospitals as a whole either.

We are confident that our hospitals bill collection procedures have been thorough and diligent, so much so, that we would welcome any internal or outside audit of that collection

system. In fact, when the Uncompensated Care Trust Fund proposal was first developed, the New Jersey Hospital Association strongly supported and recommended any mechanism of tougher auditing procedures as a check and balance mechanism. Hospitals accepting uncompensated care would embrace the comfort of any strict auditing procedures or process would bring us against the discomfort of misinformed critics.

Mr. Chairman, my allotted time is running thin. In closing let me reiterate that removing dollars from the current Uncompensated Care Trust Fund will only result in limiting access to care for the indigent of this State, and possibly prompt the financial ruin of many of our high uncompensated care caseload hospitals.

We hope that the Legislature, through the leadership of this Committee, will see fit to continue the existing Uncompensated Care Trust Fund, perhaps even bolstered by a broader-based funding source and monitored by stricter auditing procedures, if that seems to be appropriate. Taking dollars out of the uncompensated care pipe line will certainly result in deteriorating the hospital system in New Jersey even further, and will only hurt those who can least afford it.

The amount of money we're spending on uncompensated care ought to be considered a preventive cost. It is society's responsibility to continue to invest in developing effective means for paying health care costs today as a prevention, so our children aren't faced with an unsolvable dilemma of paying for more expensive health care costs tomorrow.

I thank you very much for your time -- the Association does -- and certainly for your continued interest and dedication to the health care industry in New Jersey. I would be only to happy to share the questions-- (inaudible)

ASSEMBLYMAN COLBURN: Thanks very much. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, as one of those perhaps characterized as a misinformed critic of the Uncompensated Care Trust Fund Committee, let me ask Mr. Scibetta a few questions. One relates back to one question I asked Commissioner Coye. When I served on the Trust Fund Committee, one of your representatives from the Hospital Association did state that they do not have proper data on all the individuals who enter the hospital, and it was very difficult to get some hospital patients to share with hospital administrators information that may be germane to whether they're covered by some sort of insurance policy. That was what my question was in relation to the Commissioner, relative to computerization and the ability of hospitals statewide to provide the Trust Fund Committee, or for that matter the Department of Health itself, with some assurances that the people who are benefiting from the program -- and many are, and many are needy -- that in fact if their spouse was covered by some insurance plan, that they may in fact be covered as well. That's what my question relating to the Commissioner was all about.

In other words, if somebody is a likely candidate to -- a likely indigent person eligibility -- it was said at our Trust Fund Committee that it's very difficult for hospital staff to get that information out of patients. If a system were to be devised, it would lay some expense at the foot of the hospitals to set up the system.

MR. SCIBETTA: Mr. Frelinghuysen, first of all let me apologize to you if I have suggested something that suggested that I was referencing anything you said. I certainly did not know what you said, and I didn't find any question you asked the Commissioner in any way out of order. I was referencing--

ASSEMBLYMAN FRELINGHUYSEN: I'm not sure who the misinformed critics are. They're not in this room? I hope they're not.

MR. SCIBETTA: They're certainly not members of this Committee or I wouldn't have said it-- (inaudible)

ASSEMBLYMAN FRELINGHUYSEN: Well who are they then?

MR. SCIBETTA: Well I'd rather not be that specific in public.

ASSEMBLYMAN FRELINGHUYSEN: All right. Well then maybe you can answer my question. Is there any way that a hospital can determine whether a person who comes through their doors is covered by some sort of insurance policy? And if there isn't, is there a method that could be devised using State support -- of for that matter any other support -- that can give us a better grasp as to exactly who is getting what, in the way of health care?

MR. SCIBETTA: I believe the question is whether or not hospitals were conducting their billing practices appropriately. That was the one I was trying to--

ASSEMBLYMAN FRELINGHUYSEN: Well maybe I'm asking you another question.

MR. SCIBETTA: If a patient comes in and doesn't have--

ASSEMBLYMAN FRELINGHUYSEN: When somebody comes in the door--

MR. SCIBETTA: Then there's not much a hospital-- (inaudible)

ASSEMBLYMAN FRELINGHUYSEN: What do we as people when they come in to a hospital -- a likely candidate? Is there any requirement that they're employed?

MR. SCIBETTA: We ask them-- (inaudible) --where they're employed, what their address is--

ASSEMBLYMAN FRELINGHUYSEN: Do they have to give that information?

MR. SCIBETTA: Well they have to give that information if they're able to communicate. If they're in such an emergency state that they can't even communicate, that's part of the problem. I would guess you have-- I mean, we have

people coming to emergency rooms who simply, based on the problem and so forth, and then you'll hear-- (inaudible)

ASSEMBLYMAN FRELINGHUYSEN: Well I would suspect that people who are under some stress that they wouldn't be asked necessarily whether they're covered by Blue Cross and Blue Shield.

MR. SCIBETTA: Well sir, that was what I was referencing when I said that the criticism that I've heard is that hospitals have been too diligent in collecting their bills; not, not diligent enough. It's my understanding that hospitals are very careful in asking the right questions and documenting the information that is there. I believe that there are many cases that-- You can ask the hospital executives who are going to testify here today, and I'm certain they will testify--

ASSEMBLYMAN FRELINGHUYSEN: I sat with a group of 20 colleagues on the Uncompensated Care Trust Fund Committee for five or six meetings, and one of the questions raised was whether hospitals really have a grasp on the people who are being served, whether in fact you have a way of knowing whether their spouse in any way -- if they're married or whatever their situation is -- whether there is a possibility of their being covered? I'll leave it open as a rhetorical question, and perhaps go on to another question.

MR. SCIBETTA: Well I think that the question that you're asking is, can a hospital guarantee that it can reach everybody that it catalogs when they come in for service? The answer to that is, no. If a patient gives the wrong address, and they're an emergency patient, and you go to that patient or a collection agency goes to that address and there's nobody home, you can't collect that bill. That is uncompensated care patient. That's what is historically classified as a deadbeat. I don't know that the hospitals will ever be able to trace that. That's a serious problem. That's the

classification of those who don't pay, as opposed to those who can't pay.

ASSEMBLYMAN FRELINGHUYSEN: There is an emphasis on stronger collection. There is also an emphasis here on really getting a grasp on the individuals who serve, and determine whether in fact anyone related to them might in fact provide coverage, thereby reducing the number of people who are in the uninsured pool. Do all hospitals in New Jersey provide health insurance for their employees?

MR. SCIBETTA: My understanding is that all hospitals do provide health insurance.

ASSEMBLYMAN FRELINGHUYSEN: Wearing another hat, as a small employer -- 250 is a pretty respectable amount of employees -- you understand that the Trust Fund Committee did examine the possibility of a pilot program for small businesses, to see whether there was any way we could -- and I use the word in a positive sense -- entice them into some sort of an arrangement where they would provide basic health care for their employees. Do you provide such a service, and do you see merit in such a pilot program?

MR. SCIBETTA: I think there is merit in a pilot program. I think it is appropriate for health insurance coverage to be provided. That's the reason we provide it for our own employees. We also have initiated a group health insurance program that many many hospitals in this State subscribe to with regard to their own employees. We have about 46,000 people, employees from hospitals, who are enrolled in this group program through the Hospital Association for group health insurance coverage. We restrict it to the hospital employees as a group at the moment. There are some others-- (inaudible) --very limited. It works very effectively.

ASSEMBLYMAN FRELINGHUYSEN: Hospital employees and their dependents?

MR. SCIBETTA: Hospital employees and their dependents, yes.

ASSEMBLYMAN FRELINGHUYSEN: I'm not sure I got the answer -- one more question -- maybe I can ask it again. Do you see merit going after the pilot program as a way of enticing small businesses into the, I think, very necessary program of providing health insurance for their employees? Do you see merit in that as a proposal?

MR. SCIBETTA: Mr. Frelinghuysen, we've supported that concept. The problem with the pilot program that is voluntary is that people don't participate. Then the question of equity comes in. That's what really bothers the business leadership in this State; that some people are providing their fair share of insurance coverage for their employees and others are not. So somehow the mechanism of -- that I believe is on the table -- concerning themselves with those who don't provide health insurance coverage, that they might have some tax mechanism attributed to those people whereby those dollars could be then attributed to the Uncompensated Care Fund, I think that would be very equitable, and an appropriate direction to take. Perhaps we would generate more support from the business community than we have in the past-- (inaudible)

ASSEMBLYMAN FRELINGHUYSEN: Good. Thank you. Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Mr. Chairman, earlier-- This is no reflection on the hospitals or on anybody at this moment. I'm bothered by the reflection of costs and how they're escalating. For example, 20 years ago the freeholders were probably paying the hospitals totally about $30 million to $40 million a year through the State for indigent care. Maybe that figure is high, that 20 years ago they were paying that kind of money. Now we come to the point where we have an increase-- In one year there's going to be a shortfall of $50 million; in one year. This gives you some idea of how rapidly these costs are escalating. As a matter of fact, there is no indication that they're going to be leveling off.

What I'm concerned about with this rapid escalation, and with the fact that this present system of course is funded by people who are insured-- It's a question of how much those insurance companies can stand before your surcharge gets to be such a burden that the whole thing gets out of whack, providing, of course, this escalation continues on this rapid path that it's on now. Making that point, one of the questions that I wanted to ask at this point -- and I don't know if you're in a position to answer it -- what has AIDS done to the hospital program and to hospital costs, and to people who do not have the ability to pay where it's transferred to this fund? Do you have any figures on that or any ideas about what that would cost?

MR. SCIBETTA: Overall, I don't have any figures on it. But we do know that the AIDS dilemma in New Jersey is probably one of the greatest concerns that the hospitals have. The question they're facing is, how are we going to be able to take care of the increasing numbers of patients that we have to concern ourselves with, because, whether we like to admit it or not, New Jersey is along the corridor of New York City, which presents itself as the AIDS corridor of the world. I've heard figures of estimates somewhere between $11,000 and $12,000 per case to take care of an AIDS patient.

ASSEMBLYMAN OTLOWSKI: In the course of the year-- We're talking of 400 million at the present time, 450 million next year. You don't have any perception at all of the millions of dollars, or if it's costing millions of dollars at this point, if it's imposing that kind of burden on the system? In millions of dollars would you say?

MR. SCIBETTA: Mr. Becker tells me that he thought that figure was about 15 million this year for AIDS patients.

ASSEMBLYMAN OTLOWSKI: About 15 million?

MR. SCIBETTA: Yes. And it's totally inadequate, and I think that's precisely one of the issues that the Department of Health is addressing this year, to try to reimburse hospitals for something anywhere reasonably close to-- (inaudible)

ASSEMBLYMAN OTLOWSKI: All right. That's 15 million. Following that question, what in your opinion, in terms of millions, would the drug problem be imposing on hospitals?

MR. SCIBETTA: I wouldn't have any idea as to how to estimate that.

ASSEMBLYMAN OTLOWSKI: Again, from off the top of your head, would you say that that could be about 20 million to 25 million?

MR. SCIBETTA: I have no idea. I would say that the greatest cost that hospitals are concerning themselves with right now have to do with labor. Labor costs and the crisis that exists in the shortage of manpower in this State, is the greatest single concern that hospitals have, because hospitals are labor intensive industries. It's 50% to 60% of the total cost. When you're looking at cost increases, whether it's called uncompensated care or whether it's called Prudential Insurance Company, those cost increases are predominantly labor and they are-- (inaudible)

ASSEMBLYMAN OTLOWSKI: Is this what you're saying, that in the past 20 years, when these costs were, but now so minimum, that in the past 20 years this great escalation is primarily resulting from labor costs?

MR. SCIBETTA: What I'm saying is that in the past 20 years, the hospital system in New Jersey has been under-funded, for openers, considerably under-funded, dramatically under-funded, and that's the reason our costs are--

ASSEMBLYMAN OTLOWSKI: Well if you didn't have any labor costs you wouldn't be under-funded.

MR. SCIBETTA: And labor for us--

ASSEMBLYMAN OTLOWSKI: No. I want to bring this into focus. I'm not faulting the hospitals. I just want to see the changes that are taking place here that are imposing these kinds of costs. You said a moment ago that one of the great costs -- aside from what I mentioned, the imposition of the drug patient, the imposition of the AIDS patients -- you said that labor costs were one of the biggest factors.

MR. SCIBETTA: Yes, sir. That's correct. That's true in terms of increases too.

ASSEMBLYMAN OTLOWSKI: Yeah.

MR. SCIBETTA: The labor costs are going up at higher rates of increase now than they ever have in the past because of the shortage of manpower -- in this case, primarily womanpower -- in our hospitals, and tremendous competition for that small pool that exists from Philadelphia and Eastern Pennsylvania and New York City. So those rates of increase are just going right through the sky, and that's having a dramatic increase on our costs. We have to maintain those--

ASSEMBLYMAN OTLOWSKI: And then aside from the labor costs that have increased, as you put it, so dramatically, the changes in technology has a tremendous impact upon hospitals.

MR. SCIBETTA: A tremendous impact, you're absolutely right on target. The technology, the labor, the AIDS, other factors, are tremendous costs that hospitals have no control over, and I think that-- (inaudible)

ASSEMBLYMAN OTLOWSKI: So what we're saying is that we're in a totally different ball game, say than in the ball game we were in a few years back.

MR. SCIBETTA: Yes.

ASSEMBLYMAN OTLOWSKI: And each year of course intensified the whole thing.

MR. SCIBETTA: Each year intensifies it, and the bigger challenge exists every year for hospitals to simply stay solvent, and they continue to provide the good care they're providing.

ASSEMBLYMAN OTLOWSKI: Mr. Chairman, I thought of a question when I asked the question: I thought that some of these social problems that I was talking about that the costs would be greater, but I see that as a result of my questioning the real increases come from labor and the technology that has developed in hospitals. No question that the other social ills that we have, contributed to the increased costs.

MR. SCIBETTA: Very true, and the aging of the population. The most expensive people to take care are the elderly.

ASSEMBLYMAN OTLOWSKI: Well I like that. I like the aging. (laughter)

MR. SCIBETTA: The alternatives aren't very good. We are the second oldest state in terms of the median age in the country, and it does take more dollars to take care of an older patient than a younger patient. So that's another challenge for us.

ASSEMBLYMAN OTLOWSKI: Well I'm glad to hear that you're not against aging. I just wanted to get some perspective of this whole thing.

ASSEMBLYMAN COLBURN: We're his best customers, Mr. Otlowski. (laughter) We are. I'm in that same group.

Mr. Scibetta, I wanted to ask you a couple of things. First of all, I don't think I've seen any word from this Advisory Commission -- and you referred to that, and I think you said the Commissioner referred to that. I've been missing things from the Advisory Commission. That's one reason we're having the hearing right now when we are, because I've been disappointed that we haven't had word. Has there been word from the Advisory Commission?

ASSEMBLYMAN FRELINGHUYSEN: Well, there's been plenty of material, Mr. Chairman.

ASSEMBLYMAN COLBURN: But no report, I guess. Has there been any composite report that any of us have had access to?

ASSEMBLYMAN FRELINGHUYSEN: You've had access to all the working documents. I don't think there's actually a published report.

ASSEMBLYMAN COLBURN: But no final-- Okay, I just wanted to be sure about that. Can we find out how many people are benefiting by the $450 million, how many patients?

MR. SCIBETTA: I don't have those numbers, but--

ASSEMBLYMAN COLBURN: Does anybody have them, do you think?

MR. SCIBETTA: I would think the overall total has got to be a known factor.

ASSEMBLYMAN COLBURN: Okay, I just wondered. I think we'd be interested in knowing numbers of people and things of that kind. Have any people been taken to court, do you suppose, that haven't paid?

MR. SCIBETTA: Oh, yes sir.

ASSEMBLYMAN COLBURN: They have?

MR. SCIBETTA: That is part of the process, no question about it.

ASSEMBLYMAN COLBURN: And can we get some information about under what circumstances they go to court?

MR. SCIBETTA: Well basically that relates to the collection efforts once it's turned over to the collection bureau. If they don't pay within a certain period of time, or if they don't set up a justified collection process where they're paying so much on a regular basis depending upon their means, then they're automatically brought to court to settle the situation.

ASSEMBLYMAN COLBURN: And if some payment is made, then they wouldn't be in this uncompensated care category, or maybe in part they would? Would there be times when you'd get some of the money but not all of it, and there would still be money coming out of the fund to make up for it?

MR. SCIBETTA: But then that would be reconciled at the end of the year, so it wouldn't be a net decrease of the fund. The hospital wouldn't get paid double.

ASSEMBLYMAN COLBURN: No, no, no. I'm not asking that. I mean, if they did collect from the court then it would be less from the Uncompensated Care Fund, I guess?

MR. SCIBETTA: That's correct.

ASSEMBLYMAN COLBURN: Okay. Is there any difference between a surcharge on the type of payer that there is, like the Blue plans and the private insurers as opposed to an HMO? I mean, do the HMO patients get surcharged as much as the other patients?

MR. SCIBETTA: It is my understanding that every patient's bill is surcharged the same amount, regardless of the--

ASSEMBLYMAN COLBURN: And is it the DRG of the patient--

MR. SCIBETTA: It can be different.

C R A I G A. B E C K E R: HMOs under Federal law are allowed to--

ASSEMBLYMAN COLBURN: They have some kind of discount don't they?

MR. BECKER: --get their own discounts. We can't control that.

ASSEMBLYMAN COLBURN: No, but what I'm saying is this, would the surcharge be less for someone under an HMO having their gall bladder removed than they would for another type of payer for the same service?

MR. BECKER: The surcharge would be the same but the cost of care would be-- (inaudible)

ASSEMBLYMAN COLBURN: Okay. So the surcharge going into the fund--

MR. BECKER: What they pay may be different, but the percentage is the same. In other words, the DRG rate from the hospital is the same.

ASSEMBLYMAN COLBURN: Okay.

MR. BECKER: It doesn't make any difference who's paying that bill. That DRG rate is calculated--

ASSEMBLYMAN COLBURN: Now, the surcharge is levied on the DRG rate?

MR. BECKER: The DRG rate includes whatever the total charge is, which includes the uncompensated care proportion.

ASSEMBLYMAN COLBURN: I'm just trying to find out if under the HMO arrangement whether there's less money going into the fund from such a patient than there would be from a patient getting paid for by something else.

MR. SCIBETTA: I'd like to defer that to the Department of Health, so I don't mislead--

DEPUTY COMMISSIONER GRANT: (from audience) If an HMO has successfully negotiated a discount for its patients, it is theoretically possible that 10% on that lower bill would be less than--

ASSEMBLYMAN COLBURN: Less dollars going into the fund for that patient. Well, that's what I was trying to find out.

DEPUTY COMMISSIONER GRANT: I would say that that's certainly not the rule. That that does not happen all that often-- (inaudible) Theoretically that could be--

MR. SCIBETTA: Theoretically, that's possible.

ASSEMBLYMAN COLBURN: Well, I frankly don't know in detail how the HMOs operate, except I thought they usually -- and maybe I'm wrong here again -- I thought they would negotiate frequently a lower rate to enable them to have premiums that were competitive in their own field.

DEPUTY COMMISSIONER GRANT: We have to go back over the figures to give you an exact amount. My experience is now somewhat dated, but I know as recently as about 18 months ago-- (inaudible)

ASSEMBLYMAN COLBURN: Okay. We would want to look more into what the effect is of the type of payment. I got a

bill from a man up in North Jersey whose wife delivered a baby a couple of years ago, and he, I believe, showed a sizable surcharge on his bill to which he was objecting of course, because he paid it himself. He didn't have any coverage. It was a good size amount. So I didn't know if the HMOs would contribute more or less to the fund than the Blue Cross/Blue Shield, or whatever.

Let me see if there was anything else I wanted to ask you. Thanks a lot. I guess we'll maybe think of other things later on, not necessarily today but some other time, because we'll be going into this all over again when we really hear bills.

MR. SCIBETTA: Thank you very much, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you very much,

MR. SCIBETTA: We'll be happy to help anyway we can.

ASSEMBLYMAN COLBURN: Well we sure appreciate it. Sister Margaret Straney, President and Chief Executive Officer, Cathedral Health Care System, Inc.? Good afternoon.

S I S T E R M A R G A R E T J. S T R A N E Y: Good afternoon.

ASSEMBLYMAN COLBURN: Are you representing the entire state of the--

SISTER MARGARET: No, I'm representing the entire system.

ASSEMBLYMAN COLBURN: Which covers?

SISTER MARGARET: Three hospitals.

ASSEMBLYMAN COLBURN: Oh okay. Excuse me. Are they in Newark?

SISTER MARGARET: Yes.

ASSEMBLYMAN COLBURN: Okay. I couldn't remember. Thank you.

SISTER MARGARET: Mr. Chairman, members of the Committee, my name is Sister Margaret Straney. I am the President and Chief Executive Officer of Cathedral Health Care

System. With me is Mr. Jeff Warren, who is the Executive Vice President of the system.

Cathedral Health Care System is a multi hospital system sponsored by the Archdiocese of Newark, which owns and operates three hospitals in Essex County, Saint Michael's Medical Center, Saint James Hospital -- both in Newark -- and Saint Mary's Hospital in Orange. Because we have one of the highest percentages of uncompensated care in the State, we are keenly interested in Assembly Bill 3476 and the impact it could have, not only on our institutions, but on those individuals for whom the provision of uncompensated care has become a health care safety net.

For Cathedral Health Care, the New Jersey Uncompensated Care Trust Fund is more than an economic issue. It speaks to our mission as a Catholic health care system and our priority commitment to address the special needs of the poor.

In speaking to the mission of the Cathedral Health Care System, Archbishop Theodore E. McCarrick has said that we must be Catholic, we must be excellent in everything that we do, and have a special commitment to the care of the poor.

In addition to the many concerns faced by all hospitals, Catholic hospitals must address special issues related to their identity and mission. Catholic tradition mandates a special concern for the poor. We realize, however, the limitations imposed in today's environment, and also the need for us to be creative in terms of provisions here. Catholic hospitals generally have no greater financial resources than any other hospital to provide care for the poor; yet we feel a greater obligation to provide such care, and are frequently sought out to provide this care, simply because of the nature of our facilities.

We believe in the intrinsic dignity and value of each human being. Clearly, if human dignity is to be fully realized, then individuals must have the means to achieve it. And since those in need often do not have access to the means necessary for full human development, they have what we believe is a special claim to the assistance of others.

Compassionate care and respect for human dignity are not exclusive prerogatives of Catholics or their institutions. What is exclusive is that this compassionate care and regard for human dignity, are gospel mandates in a Catholic health care facility. As an inner city hospital system, we serve a large population that is poor and which, as a result, has greater health care needs than the general population. Moreover, it is not uncommon for hospitals such as Saint Michael's Medical Center and Saint James to serve as the primary care providers for many individuals. Additionally, inner city hospitals are providing most of the care to AIDS patients, which is placing an ever increasing burden on the limited resources of our institutions.

We are fortunate that the State of New Jersey has provided the leadership, the vision, and the compassion to create a Trust Fund that assures the poor access to essential health care. Since the enactment of Public Law 1978 -- we have witnessed the dramatic benefits that the payment of uncompensated care has brought to New Jersey hospitals. Institutions that previously could not rebuild severely antiquated facilities or purchase essential equipment or hire necessary personnel, were suddenly able to do so. The provision of uncompensated care has strengthened those hospitals that have consistently taken care of the poor, regardless of the financial consequences. Inner city institutions including Saint Michael's Medical Center not only provide essential services to their community, but also serve as major tertiary teaching hospitals. Many of these

institutions are heart centers, cancer centers, dialysis centers, and hemophilia centers, and are critical to New Jersey's health care delivery system.

Last year Cathedral Health Care System provided $23 million in uncompensated care, which represents 21% of our gross revenue. What we have seen is a steady increase in care to the poor, which tells us that existing government programs are not providing sufficient support and that people are falling through the cracks. These are the people who come to our hospitals with little or no income, without adequate housing, without family support, and with serious health problems that have long been ignored and will likely require an extended hospital stay. We are seeing an ever increasing number of AIDS patients who are primarily drug abusers, and who have no money whatsoever but still require frequent and sometimes lengthy, hospital stays. These social dynamics, combined with a reimbursement system that limits hospital revenues, makes it impossible for our facilities to absorb any more of these costs than we presently are.

We are extremely pleased that legislation is being proposed to extend the Trust Fund for two additional years. However, we are deeply concerned about key provisions in the bill that seek to cap indigent payments to hospitals at seven percent, and reduce by three percent rates of reimbursement to hospitals that receive payment from the Trust Fund. If these provisions are approved, the financial impact on our hospitals would be considerable.

I might add here that we also are a major employer. Within the Cathedral Health Care System we employ approximately 2500 people.

To put this matter into perspective, let us look at the facts: In 1987, Cathedral Health Care System provided $23 million, or 21% of approved revenue in uncompensated care. In 1988 we will provide 26 million, or 23% of revenue.

Depending on how one interprets the provisions of this bill -- and we're a little bit unsure -- we could potentially lose a minimum of $800,000 per year, or in a worst case, $17 million per year.

We are concerned about the increasing costs of uncompensated care, but we believe the answer is not in capping funds to support care to the poor, but rather in creating incentives for the poor to utilize pre-paid managed care programs and other cost-effective approaches. Additionally it would be prudent for the State to consider establishing a more equitable approach so that the burden does not fall disproportionately on those who use hospital services. Further, the solution to the care of the poor should not be the sole responsibility of the State. Insurers, special groups, and health care providers, must share in the solution. As an example, we feel at Cathedral Health Care System that we have a responsibility to collaborate with other providers to improve the general health status of that population. Over time, innovative educational programs and delivery systems must reorient the poor population from acute care facilities to other levels of care. We must do more with education, prevention, and must establish other avenues, particularly with primary care services.

There is another factor in all of this, and that is the effect that budget cuts have had on the most dependent members of society. As Bishop Joseph Sullivan of Brooklyn has said, "In the end, the churches and the voluntary sector cannot be expected to fill the growing gap created by Federal and State budget cuts. While the religious community has been, and will continue to serve those in need, our efforts should not be viewed as a basis for government abdication of its own responsibility." We find that New Jersey has not done that. Some have challenged the very notion of entitlement, and have said that people are not entitled to any service such as health

care. This I see as the antithesis of our Judeo-Christian tradition.

The issue of payment for care of the poor is complex, but I believe that a fair and equitable approach can be found. We are prepared to work with this Committee, with the Department of Health, and with any others who share the same concerns. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: I'm not sure, Mr. Chairman, that this question is for the Sister. Maybe it's for the Department of Health. New Jersey as I remember did get the first Medicaid AIDS waiver in the U.S. And from what I remember, it supposedly covers anyone who has AIDS and has no health insurance. Do you interact with that? Do you access that waiver?

SISTER MARGARET: Yes, we do--

ASSEMBLYMAN FRELINGHUYSEN: Is it inadequate?

SISTER MARGARET: --but we still lose, on the average, $2000 a case. At Saint Michael's Medical Center, within our system we handle a majority of our AIDS patients. On any given day we would have between 30 and 40 new patients.

ASSEMBLYMAN OTLOWSKI: How many, Sister?

SISTER MARGARET: Pardon?

ASSEMBLYMAN OTLOWSKI: How many a day?

SISTER MARGARET: Between 30 and 40.

ASSEMBLYMAN OTLOWSKI: A day?

SISTER MARGARET: A day. Our daily census would include AIDS and AIDS related diseases.

ASSEMBLYMAN FRELINGHUYSEN: Why do you lose money if the waiver, as I understand it, is supposed to pick up bills? I know obviously you have to have specialty nursing around the clock, a greater degree of care than perhaps other people in your institutions. Why in fact doesn't that waiver pick up more? I'm just asking this out of a general lack of information.

SISTER MARGARET: It's my understanding -- and again you have to realize that I'm at the system level and not at the individual hospital level -- but the payment is inadequate. And we have difficulty establishing-- Relating to Mr. Otlowski's question before, and your question before: Can we get the information? Yes, we get the information. Is the information accurate? No, particularly with AIDS patients.

ASSEMBLYMAN FRELINGHUYSEN: All right. Thank you.

ASSEMBLYMAN COLBURN: They would give you false names and so forth?

SISTER MARGARET: Yes. And frequently what happens is that they may have an aunt, uncle, or cousin who provides them with a residence, and then once they are diagnosed as being AIDS patients, the aunts, uncles, or cousins disappear and carry no responsibility for the individual, particularly with the AIDS patient who is an IV drug user.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Sister, Assemblyman Frelinghuysen raised a question and it isn't clear in my mind. Maybe you can help clear it up. With the AIDS patient, can he be picked up by Medicaid? Is he picked up by Medicaid? And are you saying that Medicaid is not sufficient to carry the cost? (affirmative response) You're saying that? Would you be better off under this uncompensated care system? You would be better off?

SISTER MARGARET: I believe so.

ASSEMBLYMAN OTLOWSKI: You'd get a better shot. Money-wise, you'd get a better shot.

SISTER MARGARET: I believe so. I can't be absolutely certain of that because I'm not sure of the patient mix among all of our AIDS patients.

ASSEMBLYMAN OTLOWSKI: The series of institutions that you mentioned in the Archdiocese, you're probably carrying the biggest load in the State. Am I correct about that?

SISTER MARGARET: One of the biggest.

ASSEMBLYMAN OTLOWSKI: One of the biggest? The other big loads would be where, Sister? Would you have any idea?

J E F F R E Y A. W A R R E N: University Hospital in Newark probably has the most.

SISTER MARGARET: Jersey City Medical Center.

ASSEMBLYMAN COLBURN: I was going to ask whether the Catholic hospitals have any special problems in putting into effect the collection procedures that the State is asking for? In other words, do they have trouble with the very compulsory attempts to collect, since they were started, I guess, as charitable institutions?

SISTER MARGARET: We've never had difficulty with any of the audits, as they presently exist. I don't know that if they get much more stringent whether we will or not.

ASSEMBLYMAN COLBURN: Okay, but up to now, you've been able to follow those protocols. Let's see. I was going to ask you something else. Oh. I don't know whether I should be asking you this or somebody else, but I thought that Medicaid was supposed to pay the audited costs of hospitals? Was it ever correct, and is it no longer correct, or am I wrong?

MR. WARREN: I don't know.

ASSEMBLYMAN COLBURN: Do we have Human Services people or-- Yes?

DEPUTY COMMISSIONER GRANT: (from audience) Medicaid pays the full DRG bill for inpatient care.

ASSEMBLYMAN COLBURN: Well is there something insufficient about AIDS, then?

SISTER MARGARET: The AIDS DRG reimbursement--

ASSEMBLYMAN COLBURN: There's no AIDS DRG?

DEPUTY COMMISSIONER GRANT: I think what the Sister is referring to is that there has been some debate as to whether a particular DRG rate which all payers pay equally, is in fact adequate to cover the costs of AIDS patients who-- (inaudible)

ASSEMBLYMAN COLBURN: Well, I think as AIDS has been currently defined, it's a symptom complex. An AIDS related complex is a different set of things, and I think there's a move toward making a diagnosis of HIV infection overall, as opposed to either AIDS or ARC. Now, when a person has the problem of the immune deficiency they get a variety of infections, some of which are harder to treat than others. So, I would think that we ought to try to sharpen our definitions within those diagnostic categories in order to maximize what we can get from a Medicaid payment. Maybe we don't have this thing properly directed.

DEPUTY COMMISSIONER GRANT: I think Mr. Knowlton has left, so I won't presume to speak for him from the rate setting side, but you should be aware that, in fact, the Department has increased the per AIDS case payment for AIDS patients. The Rate Setting Commission approved of that. In addition, the Department has announced plans to adopt-- (inaudible) -- the AIDS DRGs--

ASSEMBLYMAN COLBURN: Okay.

DEPUTY COMMISSIONER GRANT: --at which time there will be further balancing of actual costs of care for such individuals, based on their clinical diagnosis and their-- (inaudible) It's a different issue-- (inaudible) --than the uncompensated care issue. It's a different issue which is being addressed. It has some impact on uncompensated care, but I'd be very disappointed if you left feeling it is a disproportionate amount of uncompensated care, which is not the case.

ASSEMBLYMAN COLBURN: Well if a hospital got too little under Medicaid for an AIDS patient, I guess they cannot then, by definition, go after the Uncompensated Care Fund? Is that correct?

DEPUTY COMMISSIONER GRANT: That's correct.

ASSEMBLYMAN COLBURN: So that subject is, as you say, apart from the-- Okay. Thanks a lot. We'll be discussing this further in the next few months, I guess.

Sister Jane Francis Brady, President of the St. Joseph's Hospital and Medical Center in Paterson? Good afternoon.

S I S T E R J A N E F R A N C E S B R A D Y: Good afternoon. My name is Sister Jane Frances Brady, and with me here at my right is Thomas Black, who is our Vice President of Financial Affairs.

For the past 16 years I have been the President and Chief Executive Officer of St. Joseph's. I might also tell you that I serve presently as a member of the Health Care Administration Board in the State of New Jersey. I served on the Catholic Health Association nationally, and specifically on the Task Force on Health Care for the Poor for several years.

By bed size, St. Joseph's Hospital, which is one of the four divisions of the Medical Center, is the second largest private hospital in the State, currently operating at 100% capacity on a daily basis, and clearly one of the biggest and busiest hospitals in New Jersey.

We are second only to the Jersey City Medical Center in the amount of free care provided to those who can pay nothing for their care. In 1987, that free care at St. Joseph's amounted to $19,845,000. For purposes of questions, and a distinction that you drew before, I might point out that 16,400,000 of that amount was classified as charity care, and the remainder classified as bad debt. In inner cities that still constitutes care to the indigent.

I would like today, in the few minutes that I will take, to provide you with a brief background on the reimbursement of free care in New Jersey from the point of view of the CEO, of what that has meant specifically to my institution, and what a cutback or a cap of that reimbursement

would mean to the people in the City of Paterson and in the County of Passaic. I should note for those purposes that there is no city hospital in Paterson; neither is there an acute care county hospital in Passaic. For all intents and purposes, St. Joseph's functions in both of those roles.

St. Joseph's was founded in 1867 to care specifically for the sick and poor, and for 121 years has steadfastly held to that until this very day, where we remain where we have always been, on Main Street in Paterson -- midway through a $78 million expansion program.

The value of the free care that we were giving to the poor mounted with the decades, until by the mid-1970s it was well into the millions of dollars annually. By the mid-1970s it was crystal clear that while St. Joseph's was one of the busiest hospitals in the State, filled everyday to capacity, it was technically bankrupt because of the deficit created by the free care burden it carried. Vendors waited six months to a year to be paid. Drugs and food were delivered C.O.D. The situation was desperate.

And so, St. Joseph's took a leadership position in forming what we then called the Urban Hospital Coalition -- comprised of the major inner city hospitals of the State -- and we lobbied for the inclusion of free care as one of the elements of cost to be reimbursed under the then proposed public law, S-446.

After years of work, debates, and negotiations, we succeeded in having indigent care specifically delineated as a reimbursable element of cost for all hospitals in this State. S-446 was signed into law in 1978, and implemented beginning with January 1980, with the DRG methodology.

The change for urban hospitals like St. Joseph's was nothing short of dramatic. For the first time in 114 years, St. Joseph's actually ran in the black. Finally the revenue required to run our immense operation was actually coming to

us. Financial health meant payment of vendors, raising of employees' salaries to meet those paid elsewhere, the opportunity to improve facilities neglected in the lean years we had never been able to put behind us.

In January of 1987, the method of paying this element of cost -- as you have heard -- was changed. Through an add-on to the rate for every hospital in the State, an Uncompensated Care Trust Fund was created which properly shared the responsibility for, and the costs of, providing indigent care. Now we all share in this task, some by contributing to the fund, others by billing the fund for the care actually rendered to the indigent in their service area.

In my view this is an equitable way of distributing what is clearly a shared responsibility for care of the sick poor of our society, because it binds us -- both urban and suburban hospitals -- in the response to this compelling need.

It is important, I think, for the Committee to understand that no suburban hospital loses money by paying in to this fund. This is so because all hospitals are given an added amount up-front in their rate which they either spend only for indigent care or which they must contribute to the fund for indigent care delivered by other hospitals. Absent this fund and this mechanism, hospitals would not have received these added monies in the first instance.

Unfortunately, the provisions to create this Fund also set a sunset date of December 1988 for its expiration. It is no secret that a number of hospitals who do not have the problem of caring for the indigent, are lobbying hard to discontinue, perhaps, this established and successful method of reimbursing indigent care. Such a move would force St. Joseph's and large, urban hospitals like us back to the quasi-bankruptcy days of the 1970s, and it would be no exaggeration to speculate on possible closures of some of these institutions. I am here today to tell the Legislature, through this Committee, that this cannot be permitted.

Governor Kean, as recently as last May, made a public commitment in an address to the New Jersey Hospital Association that New Jersey would continue to ensure care of its sick poor, and he took great pride in his leadership and that of New Jersey on an issue which many states have refused even to address. You heard today directly from her -- that Dr. Molly Coye, our Commissioner of Health, is committed to the principle of reimbursement of indigent care. But she cannot keep that commitment if legislative action is taken to change what I view as a solemn commitment enshrined in the public law of this State.

We can not, and we will not, return to the old days. Speaking for St. Joseph's, I am proud to say that we have kept absolutely to our moral commitment to the sick poor. But we have many moral commitments to keep:

- We employ 3300 people.

- We care for 250,000 patients in our Medical Center each year, the vast majority of whom pay for their care.

- We have 500+ physicians practicing first class medicine in our hospital, and our hospital serves as a referral center for tertiary care services for another two dozen hospitals in its area.

- We have a moral commitment to the hundreds of vendors who supply and service our institutions.

If the State were to make the decision that hospitals like St. Joseph's could no longer be paid full cost for the care of the sick poor, then I think the State would have to assume its legal responsibility to provide those services itself, or through another mechanism. The only money available to urban hospitals like mine is that which comes through the reimbursement. Absent that, there are no resources to assume what may be, and indeed is, a very serious moral responsibility for us, but I believe a legal responsibility of the government.

So I would urge that you as Committee members not permit anyone to return us to the shameful situation we once had of the poor being denied access to hospital care they desperately needed, and the very difficult situations that hospitals like ours faced, in having patients literally dumped in our emergency room. As fourth in the nation in the number of AIDS patients, most of them indigent, please do not force us to have them go without what little care and comfort we can give them. Do not force hospitals like St. Joseph's to cut back on care to the poor in order to survive as an institution. Don't allow our New Jersey hospitals to go into the same category as many others in our nation, who have indeed been forced into that posture.

I believe that a society is judged by the care it takes of its weakest members. In this care we would include the sick poor, the homeless, and the AIDS patients. As one of the strongest economically in the nation, I don't believe that New Jersey can take the position that we cannot take care of these people.

I thank you for the opportunity to offer these thoughts for your consideration. I would be more than happy to answer any questions that the Committee might have.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No questions.

ASSEMBLYMAN COLBURN: Mr. Otlowski? Whoops. What happened to him? He headed north. Did he leave? (negative response) No, okay.

Sister, I wanted to say one thing to you. It's very easy up here, and really the routine, to become paranoid on most occasions. But I want to tell you that when I wrote this bill -- to which most everyone here objects, (laughter) we might hear a different view later, but anyhow most of the people here don't like that bill too much -- I heard from no hospital asking that we go back to the old system, or asking

that we take away from any of the hospitals this payment. So, it's absolutely nothing that I know to do with any action of the hospitals. As a matter of fact, the whole Hospital Association is probably now slightly miffed that somebody they thought was their friend has done this. I don't see that as part of this at all. There's no lobbying going on by any hospital that I know of.

SISTER JANE FRANCES: Perhaps I might clarify what I meant by that remark. My point goes not to the hospitals in the State not wishing for uncompensated care to be given. I think there is strong objection to the mechanism.

ASSEMBLYMAN COLBURN: By hospitals?

SISTER JANE FRANCES: By some.

ASSEMBLYMAN COLBURN: Well they haven't spoken to us, or to me, and I doubt--

SISTER JANE FRANCES: Well they have spoken on other occasions.

ASSEMBLYMAN COLBURN: Okay, well not to me.

SISTER JANE FRANCES: I think their point is that they feel that the care should indeed be given, but should be given through a different mechanism, and they're certainly entitled to that opinion.

ASSEMBLYMAN COLBURN: My problem is that I'm not real pleased with the current mechanism. I'm not even questioning the amount of money, to be honest with you, but I am questioning how we put together the financing? But I haven't heard from any hospital, believe me, and I don't know that anyone else has either. I just wanted to tell you that. I don't think you have enemies among the hospitals.

SISTER JANE FRANCES: No, no. I don't think that either. Our concern is that, with particular relevance to your bill, that capping it in the amount, unless there is another mechanism to make up that difference, will actually deprive us of money, and there is no other source for us to go to for that money.

ASSEMBLYMAN COLBURN: I recognize that, yes. Well I'd like to see the State put in a big contribution. But in spite of what the Governor said at the meeting, so far we haven't had offers of any significant contributions from the State government. So that's kind of a problem to us. I appreciate your contribution, and the directness of your testimony the way everyone else has done.

SISTER JANE FRANCES: Thank you.

ASSEMBLYMAN COLBURN: Mr. Kurtz?

L E S T E R K U R T Z: Good afternoon.

ASSEMBLYMAN COLBURN: Good afternoon.

MR. KURTZ: Mr. Chairman, I have with me Clyde Parker, representing business, and who will present the statement for the New Jersey Business and Industry Association. Mr. Parker is with Mannington Mills in South Jersey, and will present the statement for our Association.

C L Y D E P A R K E R: Good afternoon. My name is Clyde Parker. I am Director of Manufacturing Personnel with Mannington Mills. I am appearing before this Committee today representing the 11,000 members of the New Jersey Business and Industry Association. During the past 12 months I have served as a member of the New Jersey Uncompensated Care Trust Fund Advisory Committee.

The New Jersey Uncompensated Care Trust Fund -- Public Law 1986, Chapter 204 -- which was signed by the Governor on January 5, 1987, created a Trust Fund Advisory Committee. This Committee was charged by the statute with the responsibility of recommending to the Commissioner of Health, alternative methods of financing uncompensated care. The statute also affirmed the surcharge or add-on method to raise revenue for the Trust Fund, and approved the Trust Fund concept for a two-year period. The New Jersey Business and Industry Association supported the creation of the Trust Fund, while submitted that funding uncompensated care was a societal problem and urging increasing funding from general revenues.

The Trust Fund Advisory Committee held its organizational meeting in August 1987, seven months after the law was signed. During the next several meetings, the Department of Health staff provided the Committee with a variety of background information on the magnitude of the financial problem facing the State's hospitals. This information enabled the Committee to comprehend the purpose of the Trust Fund as established, and the direction given by the Legislature to the Advisory Committee.

A large amount of information was provided by the Department of Health staff concerning the demographics of the population who lack health insurance. Also, data was provided concerning the admission diagnoses of the individuals who have received uncompensated care. However, it is significant to note that, despite requests, the Department of Health has been unable to provide demographic data on the profile of individuals whose hospital care resulted in uncompensated care. The Trust Fund Advisory Committee was unable to learn what percentage, if any, of the total shortfall -- $450 million in 1988 -- would be attributable to senior citizens, to single parents, to children, to the unemployed worker, or to the employed worker who had no children.

New Jersey Business and Industry submits that without this information, it is extremely difficult to consider a realistic alternative funding method to the one which existed prior to the enactment of Chapter 204.

Despite a Department of Health regulation requiring hospitals to complete and submit a uniform bill patient summary for every patient receiving hospital care for which the hospital receives no payment, hospitals are not consistently collecting information on the employment and insurance status of the patient or the person responsible for the bill. Furthermore, where the information is collected, it is not added to the Department of Health's data base on patient

demographics. Had the Department of Health received cooperation in enforcing its regulation, a great deal of patient data would be available. It also must be noted that hospital collection efforts are seriously hampered when this vital data is not obtained. We fail to understand how the Trust Fund can properly reimburse a hospital for uncompensated care when it neglects to complete and submit the required forms? We strongly recommend that regulations be written to emphasize the importance of collecting this information from every patient and including it in a permanent data base.

In the meetings of the Advisory Committee, a good deal of time was spent exploring a variety of issues related to the cost containment and alternative insurance programs. In the opinion of New Jersey Business and Industry, perhaps too little time was devoted to an in-depth discussion of the pros and cons of alternative funding methods. Two of the most obvious means for funding uncompensated care -- additional State revenues through the budget and specific tax increases -- have not been given any serious consideration.

Although the Trust Fund has had the positive effect of assuring hospitals reimbursement for the uncompensated care provided, guaranteed payment can serve as a disincentive to collection efforts. Many of the hospitals neglect to follow Department of Health regulations. Why should they spend the effort when they will eventually receive 100% reimbursement for the services they provide to the indigent and others who do not pay for the care they receive?

Hospitals have not voluntarily sought to reduce the cost of administering medical care to those who utilize the emergency room instead of a doctor's office. Hospitals have not attempted to identify the individuals who neglect to pay their bill. We have no idea of the mix. Are they senior citizens, illegal aliens, the homeless, or the poor? The record speaks for itself.

Due to the lack of identification on the part of hospitals, their attempts at collecting bad debts are usually met with little success. We would suggest that hospitals review the identification procedures that a business or a bank utilizes before they extend credit for services rendered, and modify their procedure to their operation. It has been brought to our attention that some hospitals that provide uncompensated care fail or neglect to obtain the proper identification of an outpatient. Why should they, when the Trust Fund will fully reimburse the hospital?

Just because our law requires that all hospitals provide care to all individuals regardless of their ability to pay, does not mean that complete identification is not necessary. We submit that hospital bad debt collection should be a priority for a hospital business office.

It has been suggested that in order to reduce uncompensated care, a percentage of funds that a hospital raises privately for capital construction should be used to reduce a hospital's bad debt and indigent care. The buyers of health insurance should not be required to pay for hospital construction in addition to indigent care and bad debts. This slight change would be an incentive for hospitals to keep their uncompensated care at the lowest level.

From a business point of view, programs for dealing with the uncompensated care problem fall into three categories: those that target providers; those that target individuals; and those that provide grants to local governments to purchase indigent and uncompensated care.

New Jersey utilizes a direct reimbursement through an all payer rate setting program. This type of program places the burden unevenly on employers who provide their employees with health insurance. Uncompensated care is a problem that must be shared evenly by all taxpayers, not a small segment of taxpayers. New Jersey Business and Industry urges that the

Legislature adopt an alternative to the present method of uncompensated care. Therefore, we cannot embrace any program that targets providers, simply because this type of program would pass the burden on to the buyers of health insurance.

New Jersey is presently considering a program that would provide health insurance for the unemployed. This type of program is based on the assumption that health insurance is prepaid during periods of employment, and when a worker is unemployed the new program would provide basic health insurance protection. This program will reduce uncompensated care caused by individuals who have lost their health insurance as a result of unemployment or who cannot afford to continue their COBRA insurance protection due to the high premium cost.

Another approach is to develop a program which will provide insurance coverage, either through vouchers to purchase insurance or as an expansion of an existing program -- such as the Medicaid Medically Needy Program -- for those individuals who are currently uninsured. New Jersey has recently introduced this program on a limited basis and is currently correcting some administrative problems. We would suggest that this program be expanded to its maximum level because it includes some Federal funding.

Another program worthy of consideration is direct government payments to benefit certain population subgroups. Under this option, New Jersey could develop a mechanism to provide direct subsidies to specific individuals who cannot afford to pay for care. Under certain circumstances, this type of program could be cost-effective. An example of this program could be a special purpose program designed to provide access to care and financing for high-risk pregnant women -- the largest group of uncompensated care admissions. These programs could focus on any clearly definable population and could use cash payments, tax deductions, vouchers, entitlement programs, or any other form of direct subsidy as the payment mechanism.

There are several alternative methods for financing uncompensated care which are far superior to the present method. New Jersey Business and Industry urges the New Jersey Legislature to consider the following alternatives to the existing mechanism for funding uncompensated care.

1) Direct appropriation of State funds. The Legislature could appropriate funds directly to the Uncompensated Care Trust Fund, in conjunction with other programs. This would be a feasible approach and could take the form of a line-item appropriation of funding for the State Medically Indigent Program. We therefore urge support for A-3476, recently introduced by you, Mr. Chairman and Mr. Frelinghuysen, and awaiting consideration by this Committee.

2) The Legislature should also consider amending the Constitution to earmark a percentage of State Lottery funds and/or casino revenue funds to the Uncompensated Care Trust Fund.

3) We also urge the Legislature to at least consider increasing the general sales tax and special purpose excise tax on goods such as alcohol and tobacco. The general sales tax could be increased by a small percentage or a special purpose use tax could be adopted. The concept of targeting sin taxes from alcohol and tobacco sales to fund certain health programs is not a novelty.

The above alternative options are not aimed at generating more money to cover uncompensated care, but instead, seek to spread the burden more evenly in order to resolve a societal problem. New Jersey Business and Industry urges that legislation encompassing some of my previous suggestions be introduced as a package of bills to complement A-3476.

Business in New Jersey cannot hope to survive in today's economy, faced with escalating health care costs. The State must become intimately involved and take the lead in health care cost containment.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, I'd like to take off the heavy mantle of critic and place it on someone else's shoulders. No, I commend you for your--

ASSEMBLYMAN COLBURN: Where is Mr. Otlowski? (laughter) Where is he?

ASSEMBLYMAN FRELINGHUYSEN: Now, Lou, I've discovered who at least one of your critics is. No, I commend you for your comments.

ASSEMBLYMAN COLBURN: I wanted to ask you-- It sounded as though you felt that the hospitals really didn't know who they were taking care of, and yet in one part you said that most of the uncompensated care patients were deliveries, obstetrical cases. So, is that--

MR. PARKER: We have gotten the statistics, and also on the Committee we have heard the comment, as you alluded to previously, that hospitals don't necessarily go the extra effort to identify the patients. I think the comment was made that if someone can intimidate the admissions nurse, that information is just not collected.

ASSEMBLYMAN COLBURN: Well I know in my capacity as a physician I've heard from a lot of patients, and they weren't necessarily non paying patients -- I guess most of them were paying patients -- but they resent having all these questions asked of them, and they'll say, "What if I was dying in that room, would they ask me all these questions and just let me die before the last answer?" But, of course, in hospitals, when someone is really that sick, I'm sure they don't ask them those questions right at the very moment when they're dying. They might ask them when they're in some pain, but it's a hard thing for hospitals to do. As medical people we always hate to do that. And yet as things are going, we do have to be firmer on this, and I think patients really do have to understand the reasons for it. Some of it may be that we're not explaining why it's happening so much to them.

Another thing, I didn't understand something here. I was going to ask you what it meant. (looks through witness' prepared statement) I'll see if I could find it here. Oh yeah, under "Alternative For Funding Uncompensated Care," 1), there's a sentence that says, "Therefore, we cannot embrace any program that targets providers, simply because this type of program would pass the burden onto the buyers of health insurance." I didn't understand what that meant.

MR. KURTZ: It had been suggested that insurance companies can be taxed; a tax be placed on insurance companies to pay for uncompensated care.

ASSEMBLYMAN COLBURN: Oh, I see.

MR. KURTZ: And the net result would be that the insurance carriers would pass that burden onto the buyers of insurance.

ASSEMBLYMAN COLBURN: Premiums directly to the people that are-- Okay. I get you.

MR. KURTZ: That's right, as one source of funding.

ASSEMBLYMAN COLBURN: Okay. I just didn't understand what you meant.

MR. KURTZ: I might add one bit of information. At the present time, the 10.9% surcharge on hospital DRG rates produces approximately $200 million a year. With the contribution from the Federal government through Medicare, it picks up the other $200 million. But that is in the process of being phased out--

ASSEMBLYMAN COLBURN: Right.

MR. KURTZ: --and our prime concern is that, as the Department of Health has mentioned, that it's not inconceivable that that 10.9% surcharge within a year, 18 months, could go to 20%. And it would raise the same $400 million, but we would not have the Federal government's participation in our program. So that expresses our concern.

MR. PARKER: The same $400 million is not going to cut it. It's got to keep pace with the escalation that the Commissioner was talking about.

ASSEMBLYMAN COLBURN: Right at this point, Mr. Scibetta, do you have some different interpretation of the figures?

MR. SCIBETTA: (from audience) Yes, Mr. Chairman. I think if you have any fundamental understanding of the reimbursement system, you would understand that that statement cannot go unchallenged, because it's not accurate. At the moment, Medicare does not pay uncompensated care. The State takes part of the money that Medicare pays to whatever hospital they pay for elderly patients, and they allocate that. They allocate that and it must go into the Trust Fund. If we get paid under PPS or if we don't get paid under PPS, they do not pay for uncompensated care. PPS does not have a provision for uncompensated care. It comes out of the total amount of money that they pay for any given case. Without a waiver, PPS is going to pay the same amount of money statewide that they're paying right now. They will not pay any less. They certainly will not pay any more. And their formula in the future, with or without a waiver, will not include a provision for uncompensated care. The State, however, will continue to distribute the amount of money that comes in from Medicare to the uncompensated care system. They would just pay it to different hospitals.

ASSEMBLYMAN COLBURN: The Federal people won't object to this practice?

MR. SCIBETTA: The Federal people don't have anything to say about how the system works once it gets into a hospital system. The system that would have to function would be if Medicare paid more to a given hospital than a totally approved rate would be, then Blue Cross or a commercial insurance company's rate would be less. The hospital wouldn't get any

more money. The State wouldn't pay more money. The Uncompensated Care Trust Fund wouldn't be any bigger or any smaller. If we took the system we have today and eliminated the waiver, Medicare's allocation to uncompensated care would be exactly what it is, and the Uncompensated Care Fund would be exactly what it is. There would be no new money in it.

Now, if Mr. Kurtz and Business and Industry can tell us how we're going to get more money into the system -- into the Uncompensated Care Trust Fund -- then we would be very happy to support any bill, by any number, that he would like to design for us. But the fact of the matter is, unfortunately for the hospitals, that there would be not one more nickel with the waiver or without the waiver, today or tomorrow, and there will be no new requirements from any fund to pay for uncompensated care over and above that requirement which exists today. It would be allocated differently among payers. But no payer will pay any more, and no payer will pay any less.

ASSEMBLYMAN FRELINGHUYSEN: I think we are concerned about the rising percentage add-on, which we have heard could be 14, 15, 16%. Now, what would account for the increased percentage, if it wasn't the loss of Medicare and/or Medicaid funds?

MR. SCIBETTA: There's only two ways that uncompensated care could rise. One is that if we had a major recession or depression in New Jersey, which caused an awful lot of people whose incomes are currently at levels, to go well down below those levels. The second way would be if hospitals' payments for services provided were increased.

ASSEMBLYMAN COLBURN: The DRG.

MR. SCIBETTA: In other words, as I said to Mr. Otlowski earlier, if 55% or 60% of your hospitals' costs are wages and salaries, you know they're going to go up. They've been down. They've been held down artificially for any number of years because of the rate system. Now, as they go up, the

amount of money per DRG is going to have to go up. It's going to have to reflect those increases. And that same increase will be reflected in the uncompensated care increases as well.

If you think about the Uncompensated Care Trust Fund, you ought to think about it as basically another payer. It's as though it's its own insurance company. It pays exactly the same amount of money that Prudential would pay for a DRG case. And the irony in this argument -- which is really kind of fallacious -- is if for example a patient were overlooked in a hospital, and they became an uncompensated care patient and the Uncompensated Care Trust Fund paid for that, the insurance system pays the Uncompensated Care Trust Fund. Now, that means that the amount of money that insurance companies have to charge for premiums to cover what they pay out for it, is less, because they put that money into the uncompensated care system. So whether it becomes more or less, it balances out. It's really an artificial discussion, because the same amount of monies is coming from the same payers, going towards the same services. And if uncompensated care goes up, then Blue Cross and other payers go down. If uncompensated care goes down for the same volume of patients, then the payers themselves are paying more out of their health insurance premiums.

So the payers in this State have the best deal in the world. That's why they like New Jersey. Our hospital costs are so low. This is the best place in the world to do business, and that's why there's no for profit hospitals. It's a great system. Business has never had it so good.

ASSEMBLYMAN COLBURN: Boy, sounds like you're throwing down the gauntlet right there. Thanks very much. Anybody have any more questions. (no response) Thanks a lot, Mr. Parker, Mr. Kurtz.

Mr. Jacobi is Special Assistant to the Commissioner, Department of the Public Advocate. Good afternoon. Do you

have copies of what you're about to say? (Chairman is notified that copies were already distributed) Were they? Okay. Then we've got them.

J O H N J A C O B I: My name is John Jacobi. I am an Assistant to Public Advocate Alfred A. Slocum.

I want to thank you for calling this hearing on hospital uncompensated care and for inviting the Public Advocate to participate.

I would like to say right off the bat that the Public Advocate's comments are, in substance, quite similar to the Hospital Association's and the Department of Health's. I think it shouldn't go unnoticed that the Department of Health and the Hospital Association and the Public Advocate agree on an aspect of hospital rate setting. That doesn't happen that often.

An examination of hospital uncompensated care leads naturally to other issues of health care. As Assemblyman Frelinghuysen knows through his very active participation in the Uncompensated Care Trust Fund Advisory Committee, a hard look at hospital uncompensated care leads naturally -- and even necessarily -- to other issues of health care, health insurance, and health facilities planning.

Uncompensated care cannot be examined in isolation, but must be viewed as a piece of facilities financing, and as an organic part of the New Jersey health care system.

Uncompensated care is paid through hospital rates by virtue of Public Law 1978, Chapter 83, which fashioned a mechanism for holding hospitals accountable for the components of the patient's bill, while still encouraging them through reimbursement policy to perform their traditional community service function of providing care to the medically indigent. In 1986, the Legislature created the Trust Fund, which permitted inner city hospitals to respond to community needs without losing their ability to compete with suburban facilities.

The Public Advocate has long been concerned with hospital uncompensated care. We believe that no person in this State should be denied access to needed hospital care due to a lack of resources. We believe that patient dumping -- the practice of sending away sick patients because they are poor -- is an evil that this State cannot condone.

We also believe that the structure of hospital rate regulation is this State compels reimbursement to hospitals for the reasonable cost of providing that care. We cannot both tell hospitals that we will examine every nickel and dime that they charge, and that they must pull the cost of uncompensated care out of the air. If we demand fiscal accountability of our hospitals -- which we try to do -- we must in return provide them with the wherewithal to provide services to the medically indigent. These services are, after all, services that no one in this State -- perhaps least of all the hospitals -- would agree to neglect.

The Public Advocate comes to the uncompensated care question then with a complex mandate. We have been outspoken, particularly in the last year, in opposition to hospital rate increases. We have demanded more justification for hospitals' assertions that they are being cheated by the hospital rate setting system.

On the other hand, we have strongly supported the Department of Health's initiatives clarifying and systematizing the hospital uncompensated care system. If we believe that hospital care should not be denied to the medically indigent -- which I think we all do -- we should also see to it that care is provided in a humane and even-handed fashion. The recent regulatory initiatives of the Department of Health have moved us forward significantly in that regard.

The message we would give you today is that these two goals -- reasonable health care costs and access to hospital care for the medically indigent -- are perfectly consistent.

The charm of New Jersey's system of paying for uncompensated care has been its reliance on two basic truths: Nothing is free, and hospitals should not turn away the needy.

We must build on the successes of the past when addressing the funding questions of the future. We must, at all times, recognize that the uncompensated care system has worked remarkably well, both for those served by the system and for those who pay for it.

New Jersey has been a national innovator in structuring uncompensated care reimbursement. It has been innovative not only by virtue of the fact that hospitals treat the medically indigent -- hospitals all over the country do that -- where New Jersey has been recognized for innovation is by making that system work.

Every state has some method -- using that term loosely -- for hospital care for the medically indigent. In most cases, hospitals simply jack up their rates enough to cover indigent care, and of course, more. Some states have city hospitals that care for many of the medically indigent in the neighborhood, permitting other facilities to dump patients they would rather not treat, and often creating inefficient, publicly funded, financially unmanageable poor people's hospitals.

In New Jersey we have little or no hospital dumping for economic reasons. We provide care through general service facilities. We have a system in place for tracking the cost of uncompensated care, and for demanding accountability from facilities that we have some ability to hold accountable.

When I travel out-of-state, people in the health care field often ask me about our uncompensated care system. I've described it to medical social workers from Michigan, advocates from Maine, and private physicians from Florida and Massachusetts. I explain that New Jersey has promised hospitals that they may recover for properly provided uncompensated care.

In return, we promise those paying for health-care that rates will be guarded. Our system is a model. We have enviable hospital access, and rates that have been well below those in states such as Pennsylvania, where hospitals treat the medically indigent if and when they choose. This pact between the rate setting system and hospitals has been a success. We have little or no patient dumping, and low rates relative to surrounding markets. The Newark Star-Ledger reported this year that many New Jersey hospitals charge rates one-half to one-third lower than, for example, those charged in Philadelphia.

When I describe our system to people from other states, I find people nodding in agreement, both the private physicians and the advocates. It seems to most people to be a sensible arrangement. Because we have in New Jersey gone beyond the point where we will permit a hospital to turn away a seriously ill patient because the patient is poor. When I say "we" I include hospital administrators, government workers, and, most important, the people of this State.

The work of the Uncompensated Care Trust Fund Advisory Committee has, we believe, established that all parties agree that care for the medically indigent must be provided through efficient, available hospitals. Hospital administrators have agreed, insurers agree, and advocates agree.

The issue for the future is, what financing mechanism should be used to further our successes?

We have currently in New Jersey a system in which a very broad base of citizens have paid for hospital uncompensated care. The 90%, more or less, of New Jersey hospital patients covered by public and/or private health insurance have been responsible for the costs of the remaining 10%. In return for paying for this care through insurance rates, and for Medicaid patients through taxes, the citizens got hospital rates which are, even with the uncompensated care

factor, well below those of our neighbors in Pennsylvania and New York.

This means that a very broad base of citizens is paying for uncompensated care. The people who pay for uncompensated care are all those with health insurance in New Jersey; a group that is roughly coextensive with those who pay income taxes. Now, Mr. Chairman, that is not to slight over the point that you made earlier. People who pay for their own health care are paying for this add-on. It is not being spreaded efficiently through those people, and that is a significant issue that I don't want to pretend that I don't understand. Tax money also goes into the current system, through Medicare and Medicaid payments.

The uncompensated care add-on of approximately 11% goes into health insurance rates. It also goes into the costs of Medicaid and Medicare. In return, those paying for health insurance and government programs get, through our regulated rate setting system, hospital rates that are lower, even with the add-on, than those charged in neighboring states. And remember, 50% of the Medicaid charges, and all of the Medicare money is even more broadly spread. It comes from Federal funds.

We have been innovators in this State. We have shown the nation how the interests of hospital rate payers and the medically indigent can be balanced for the benefit of both. Now, with Medicare pulling out of the system, and with dramatically increasing health care costs making us -- properly, in the Public Advocate's view -- sensitive to the costs of every component of the hospital rate system, we must look to preserve the valuable aspects of the system while we look to the future.

The Public Advocate urges that the Legislature continue in place a system that provides hospital care for the medically indigent, while it guards and accounts for the people's health care dollars.

We urge the Legislature to consider five components of the system that will succeed the current one. Now, if these sound somewhat familiar to you it's because I think the ideas from these five items came from the Trust Fund Advisory Committee in large part, and they've been expressed in somewhat different forms by other people who have testified today.

1) The first point is that an advisory committee -- formal or informal -- with a broad-based membership should be continued in existence. The current Trust Fund Advisory Committee has generated many valuable ideas for restraining costs in uncompensated care, and holds the promise of further creative endeavor.

2) The Legislature, by instructing the advisory body to examine private insurance expansion, can enter on an experiment that promises reduced uncompensated care costs and better primary health care for the people of New Jersey.

Fully one-half of the uninsured people in New Jersey are employed or dependents of employed people. Many work for relatively low wages or in small businesses that do not offer health insurance as a benefit of employment.

The Trust Fund Advisory Committee has examined over the past year methods for reaching out to this employed but uninsured group. The potential is there to cut substantially the cost of uncompensated care, while improving those workers' access to health care.

The Health Insurance Association of America has brought to the Advisory Committee valuable ideas for structuring affordable health insurance. Those ideas deserve further study. The states of Oregon and Michigan have begun programs in this area. In Tulsa, Oklahoma, the Chamber of Commerce developed a health insurance expansion program. These plans have in common an attempt to structure and market affordable health insurance programs that will, with some inducement -- either by the use of a carrot or a stick -- move employers to offer insurance, and employees to buy it.

New Jersey could benefit from such a program, both through reduced uncompensated care and enhanced health access.

3) Another way to cut our uncompensated care bill and expand access is to make sure that every hospital patient who is eligible for Medicaid gets onto Medicaid. For every patient who is charged to uncompensated care instead of to Medicaid, New Jersey is throwing away Federal dollars equal to approximately 50% of that bill. The Federal government will pay for one-half of the hospital bills for eligible patients.

And patients desperately want to be on Medicaid. With a Medicaid card, they may have access to primary care in an appropriate setting, a doctor's office. With a Medicaid card, they may be treated before they become so ill that they need hospital services.

It is the eligibility process that must be examined. If the Medicaid system and hospital financial staff could get together, and if the eligibility determinations could at least preliminarily be made while the patient is at the facility, more Federal money could be brought into the system and uncompensated care costs could be reduced.

4) The next point concerns the medically indigent who are not Medicaid eligible. They, too, could benefit from better primary care, and so could the uncompensated care system. Not every patient who comes into a hospital outpatient department needs care in the emergency room. Emergency rooms are expensive and appropriate for emergencies, but not always for other treatment.

The Department of Health has developed two demonstration projects to divert patients from expensive emergency rooms to more appropriate settings. Such experiments should be pursued and evaluated for their cost-saving potential.

In addition, the Department of Health has proposed that the charges for patients treated in emergency rooms should be modified depending on the level of care the patient needs.

Under such a system, the provision of less than emergency level of care would be reimbursed at a less than emergency level of payment. We agree that such a system more accurately captures the cost of uncompensated care, and we agree that such a system will save the Trust Fund money. We endorse this system, and ask that the Legislature permit all hospital rates to be set by the Rate Setting Commission, and not be reference to other State or Federal reimbursement systems.

5) The last major point is the continuation of the Trust Fund. Hospitals that care for a high proportion of uncompensated care patients must be protected. Patients without any other access to care must be protected. While new initiatives are being considered, reimbursement through rates, in appropriate settings in efficient hospitals, must be continued.

Certainly, we must work to keep the cost of uncompensated care down. But we believe that some form of add-on to rates will continue for the immediate future to be necessary to maintain access to hospital care for the medically indigent, and to maintain the fiscal health of New Jersey's hospitals.

We believe that cost reduction measures should be functional, that they should be addressed to remedying the problems in the system. We ask that no absolute caps be set on the amount of the uncompensated care add-on, and that no penalties go to hospitals because they provide uncompensated care. Any absolute cap will reduce the amount of care available to the medically indigent; any penalty on efficient hospitals providing uncompensated care will surely lead to patient dumping and increased health problems.

We ask that any cost containment efforts be vigorously pursued, but not at the cost of access for the people of New Jersey to necessary hospital care.

ASSEMBLYMAN COLBURN: Thank you.

MR. JACOBI: Thank you.

ASSEMBLYMAN COLBURN: Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Yes. Mr. Jacobi, good afternoon.

MR. JACOBI: Good afternoon.

ASSEMBLYMAN FRELINGHUYSEN: On page 11 you refer to the need for Medicaid expansion. I think sometimes we dealt so much here with the add-on and the capping aspects that a lot of the good work of the Trust Fund Committee -- some of the options that we've discussed, have been put aside. I do think that a lot of positive things can be said about some of the things we've deliberated on that haven't been covered here. But you comment further on the second paragraph on that page. I quote, "If the Medicaid system and hospital financial staff could get together, and if eligibility determinations could at least preliminarily be made while the patient is at the facility, more Federal money could be brought into the system." Is that a nice way of saying that isn't being done now, and it's something that should be done and considered in the future?

MR. JACOBI: I hope it's a nice way of saying it, but I think that that is what we are saying. I must say that I lifted this idea, I believe from Ken Courey, the Chairman of the New Jersey Hospital Association, at one of the Trust Fund Advisory Committee meetings.

The problem is that patients are not being identified as Medicaid eligible patients in the hospital as often as they should be. Now, it is from my point of view true that patients in New Jersey -- all people in New Jersey who are eligible for Medicaid -- would prefer to be on Medicaid than to be drawing down the Uncompensated Care Trust Fund. They simply get more benefit out of the Medicaid system. Now, it was suggested by Ken Courey, and there was a fair amount of discussion -- as I'm sure you will recall -- that it would benefit everyone if

somehow in the hospitals, a preliminary determination could be made that a patient is Medicaid eligible, and the Medicaid system could be drawn upon for payment rather than the Uncompensated Care Trust Fund system.

Now I understand that the Department of Human Services and other actors are discussing this. I don't know the results they've come up with. And I don't know whether it means putting a county level functionary in the hospital or training hospital billing personnel, but I think we're missing the opportunity to capture, first of all, Federal funds, and secondly, to provide better care and get people out of hospitals.

ASSEMBLYMAN FRELINGHUYSEN: I am keen on capturing more Federal dollars, then drawing them down whenever we can. Obviously there's a State match that's required, which of course gives the budget people much to be concerned about. But I think it's something that we ought to look into further. I think some may feel that I have a fixation on, let's say, having a good idea as to who comes in the doors of a hospital. I'm not suggesting for minute that I'm by nature a reactionary person, that we ought to be on a mission to root out any fraud or misrepresentation, but I do think that if somebody is potentially Medicaid eligible then there ought to be something within the system to identify them. Furthermore, some of the information that we talked about, that hospitals appear to have difficulty collecting, somebody ought to be pursuing that particular issue, because I think it is germane and perhaps part and parcel of a possible solution.

In addition, on page seven at the bottom, in reference to the comment you make on the next page, "A group that is roughly coextensive with those who pay income taxes." You say here, "The people who pay for uncompensated care are all those with health insurance." Well, who actually pays for health insurance? It's the employers who, in fact, pay, and that is

some of what is the rub here today; that the major employers out there feel that they are paying over and above what they should, even though you may argue perhaps that they have the assets or the wherewithal or the responsibility to do so.

MR. JACOBI: That's a fair point. I would say that it is arguable that employers are providing health care benefits as a trade-off to higher wages. There's some bargaining that's going on. It is true, and that is an accurate criticism of my comments, that it is the employers oftentimes who are picking up the tab for health insurance. But I would argue that they're picking up the tab for health insurance often in lieu of higher wages, and that in some ways it could reasonably be argued that it is the employees ultimately who are paying for it.

ASSEMBLYMAN FRELINGHUYSEN: My attention was drawn the other day -- and I won't go on much further, Mr. Chairman -- to an article in The Wall Street Journal which was written by Edward Hennessy -- who is the CEO of Allied Corporation. Since there are no representatives here from the Hospital Association-- I know the hospital that I'm involved with that serves that corporation is concerned, in fact, about some of the actions taken by Mr. Hennessy, and perhaps other corporate leaders, to withdraw from their normal participation in involvement in utilizing the local hospital. So I think that is a factor that may in fact be something worth weighing, since corporations feel that they're paying an incredible amount towards the health insurance of their employees, and they're looking for cheaper options. So the actual financial integrity of hospitals in New Jersey may be impaired, whether we like it or not, by corporations who are going off and doing their business with one particular health insurance provider. So maybe the Hospital Association will have something else to worry about. I just wanted to introduce that into the record, as well.

Thank you for your comments. It's good to know that maybe we have identified another critic of that system. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot. You left out one article in The Star-Ledger which questioned the current system of the Trust Fund method of financing. I know you can't include all newspaper articles in your comments, but I thought you might want to just recall that one.

MR. JACOBI: Mr. Chairman, if I had an overhead projector I might have displayed the editorial cartoon that accompanies that, if we're talking about the same thing.

In response to that, however, I would like to say that I disagree with the thrust of that--

ASSEMBLYMAN COLBURN: Of the editorial?

MR. JACOBI: --of that editorial. I believe that it is unfair to overstate the case that hospital uncompensated care is being poorly spread. I think that there are arguments both ways, but I think that The Star-Ledger came out too far in one way.

ASSEMBLYMAN COLBURN: You think they misfired on that one, huh?

MR. JACOBI: I think so.

ASSEMBLYMAN COLBURN: Okay. Thanks a lot.

MR. JACOBI: Thank you.

ASSEMBLYMAN COLBURN: We were supposed to have a final witness, who may by now have given up, but somebody representing the New Jersey State Nurses Association. Is Susan Reinhard still surviving in this group? (no response) I guess not. Is there anybody else that would like to say anything about this before we close this public hearing? Yes? And the record will be kept open for any communications you might wish to send us.

J U D Y B A R B E R: (from audience) Can I stand right here?

ASSEMBLYMAN COLBURN: Sure. Come on up here if you'd like.

MS. BARBER: No, I just have a sentence--

ASSEMBLYMAN COLBURN: Let us know who you are.

MS. BARBER: I'm Judy Barber, I'm here to really learn and listen for the Mental Health Association of New Jersey. And after all I've heard, I feel-- (inaudible) --to say that our Association would certainly hope that any uncompensated care pool would cover the mentally disabled of New Jersey.

ASSEMBLYMAN COLBURN: Does it not now? I think it does. That they continue to be included, fine. Yes sir? Come on up or--

ASSEMBLYMAN FRELINGHUYSEN: Maybe, Mr. Chairman, to help the OLS recorder if we could repeat the-- Your name again is?

ASSEMBLYMAN COLBURN: Your name was Barber?

ASSEMBLYMAN FRELINGHUYSEN: And your organization?

ASSEMBLYMAN COLBURN: We have a record being kept.

ASSEMBLYMAN FRELINGHUYSEN: Would you like that for the record?

MS. BARBER: Judy Barber.

M I C H A E L M O N I H A N: I'd like to take this opportunity to introduce myself. My name is Michael Monihan. I'm the Vice President for Finance at Barnert Memorial Hospital in Paterson, New Jersey. I apologize for not having a written statement, but I found out about this meeting yesterday, and I've been sent down by the CEO, who was not able to come to this to represent the hospital.

We provide approximately 26% of our revenue in uncompensated care. We are a primary care hospital, not a tertiary care hospital. What we are finding in the City of Paterson is many of the physicians are no longer caring for the indigent, but rather sending them over to the hospitals as looking for the primary care.

We have had an extremely difficult time collecting money. What we are finding is there are many uninsured people; there are many drug users; and there are many people who are illegal aliens who do not use their right names. In fact, we've had many occasions where we can have a Xerox copy of five or six different social security cards. It's take your pick. And that becomes very cumbersome.

ASSEMBLYMAN COLBURN: For the same patient?

MR. MONIHAN: For the same patient. We've, in fact, had one lady who had an insurance card. When we pressed, her we found it wasn't her insurance card. It was her sister-in-law's insurance card, who is now down in Bogota, Colombia, but she delivered a baby and she wanted the insurance company to pay the bill. We said it's not possible. And we were informed by another gentleman that it was possible because that's how he was collecting his fee.

These are some of the anecdotes that I want to let you know; what goes on in reality in a hospital.

ASSEMBLYMAN COLBURN: Yeah, I'm a believer in anecdotal evidence, because I think it leads us into lots of interesting possibilities.

MR. MONIHAN: Let me give you an example about AIDS. AIDS, with the State of New Jersey-- The reimbursement system has given every hospital AIDS patient an add-on of $600. However, in 1982 there were very few patients incurring AIDS. The cost of AIDS has skyrocketed; let me give you an example of that. Although we are getting the $600, the drug that they use to cure the pneumonia, started in 1986 at $26 a dose. In 1987 it started at $41 a dose. In July of 1987 it was $71 a dose. It currently stands at $110 a dose. It's a normal dosage, one dose a day for 14 days. It cures their pneumonia. At that point they may be stabilized and released from the hospital. At that point we've expended in cash approximately $1600 just for the drug.

We are allowed to bill whomever we can bill, if he has coverage, an additional $600 for his stay. We're at a net loss of about $1000. That doesn't take into consideration if we had to cover him 24 hours a day with a guard because he is degenerating and doesn't remember where he is. He wanders. He spits at patients. He steals things. He lights fires. He's a threat to himself and us. Those are some of the hidden costs that are hard to quantify.

One of the cases we had was able to go home after three months, but there was no place that he could be discharged. His mother would not take him. No nursing home would take him. No halfway house could find room for him. His ex girlfriend couldn't take him. And he almost celebrated his first year anniversary in our institution. However, we were able to convince her -- his girlfriend -- to take him home.

Many of the people I tell this story to say, "Well why didn't you just discharge him to the street?" I said, "Well, we don't really do that. We like to discharge people to where they belong, or to a home or someplace." He also needed some medical care an hour or two hours a day, but not a full day. And people keep saying, "Well, why didn't you discharge him?" And I answer them, "Where do you live?" They say, "Why do you want to know that?" I said, "Because I'll discharge him to your home, or I'll discharge him to your community." They say, "Well, so what?" I say, "Well the gentleman happened to be an IV drug user, who's a transvestite prostitute." And I said, "I don't think it would be advisable to discharge him unless he's in a controlled environment." These are the kinds of people-- He was a charity case because he wasn't at the time eligible for Medicaid, and we couldn't get him out of the hospital to apply for it, and he died before he was eligible. He is an example of what the Uncompensated Care Trust Fund does. It didn't pay our true costs for him, but at least it got us some means of mechanism to allow us to get reimbursement for him.

With regard to your question as far as the data base, we have just instituted a new computer system that's "state-of-the-art." It maintains all of the medical information -- and this is the number two company in the United States as far as computers -- but they do not see the need to maintain insurance information. We are requesting that they maintain that in their system. If we pay for it, it will cost us approximately $200,000 in programming time and it would take a year to do. The reason they don't see the need, is they figure that there's a lot of people that keep changing jobs and insurance will change. Therefore, when a person comes in, you should keep asking him the questions of what kind of insurance he has. We want it because we want to do what you suggest, cross reference. If somebody came in as an outpatient three months ago and had insurance, and comes in as an inpatient now and doesn't have insurance -- or says he doesn't have insurance -- there's a way to run a cross check. We are currently doing that.

When we state that we are state-of-the-art, we have one of the newest computers installed in the State. We have a computer company-- We are the only hospital to have them, and we are trying to bring it up to the current state-of-the-art in requirements of the State. It's very difficult in programming, and getting a standard product customized. But I think that us as a hospital and elsewhere, as an industry, are trying to do that, but the computer program is very difficult.

The cost will probably be that 200,000 in programming time. In addition, it will probably cost us another 100,000 to 150,000 for hardware. All that programming time and cost would have to be appealed through the rate system. And chances of getting that approved into our rates and getting reimbursed is unlikely.

ASSEMBLYMAN FRELINGHUYSEN: Yeah, Mr. Chairman, if I can reply directly to that?

ASSEMBLYMAN COLBURN: Sure.

ASSEMBLYMAN FRELINGHUYSEN: I did share -- and Oliver Bartlett from the Hospital Association has left the room-- He had pointed out to me at one of the Uncompensated Care Trust Fund meetings, or shortly thereafter, that if the State were willing to provide the money, that it would, in fact, be a real incentive to the hospitals to do what you, in fact, have been doing on your own. I'm not sure what we're talking about in terms of a probable expense, but I do think that it is a necessary part of what we're talking about here. Not to say that it isn't extremely complex and difficult to obtain that data and find out whether it's relevant in any way, but I think it's something which might not have to come out of a system, but might, in fact, come out of some other method of appropriation. Thank you for mentioning it.

MR. MONIHAN: As far as an addition to the computer program -- the system -- we've also had them bring in a credit and collection module that now is state-of-the-art. From the moment they walk in we can make credit notices. If they say, "I have a sister living in Topeka, Kansas, and her address is that," then that's already noted on the system if the person inputs it, and that way we can track it down. It is our policy that when somebody comes in that we take a Xerox copy of as much information as they have -- ID, drivers' license, social security card, insurance cards, American Express cards, whatever -- as a mean to track it down. So we're making an effort.

One other point that the Public Advocate said. He felt that people wanted to get on Medicaid. Our experience is that many people are-- Physicians are turning away the Medicaid business. Medicaid pays, I believes it's $9 or $11 a visit.

ASSEMBLYMAN COLBURN: It's seven to the family doctor.

MR. MONIHAN: Seven?

ASSEMBLYMAN COLBURN: I guess it's being revised, but it has been.

MR. MONIHAN: It's being revised up. What we are finding is that many of the physicians in our area are just suggesting that they come to the hospital for primary care. I have personally witnessed one 15-year-old girl, in the middle of a snowstorm, bring her three-month-old baby over because the pediatrician didn't want to take care of her, because she had no money. And he said the Barnert Hospital will. She also has a one-year-old on her leg, and she had no ID. She came over from the doctor's office and we admitted the baby for pneumonia. We sent her to the clinic to be looked at and have the one-year-old looked at. Everything turned out all right. That's, if you will, some of the problems that are occurring in the inner city, too. Many of the physicians can no longer afford to take care of the indigent.

ASSEMBLYMAN COLBURN: I was going to ask you, with respect to the Medicaid patient going to the hospital, do they not get reimbursed considerably better than the physician would in his office?

MR. MONIHAN: Yes, they do.

ASSEMBLYMAN COLBURN: Because there's, I thought, the requirement that the hospital be reimbursed its audited cost for a Medicaid patient.

MR. MONIHAN: The hospital is able to be reimbursed its 1982 costs plus inflation.

ASSEMBLYMAN COLBURN: Oh, '82 plus inflation?

MR. MONIHAN: '82, yes.

ASSEMBLYMAN COLBURN: Okay. You know, when Medicaid started, the State of New Jersey, I think, caused a big problem by really encouraging patients to go to inner city hospitals instead of the practicing physicians. I was in the Medical Society at the time, and I've said this story before. There was a doctor in Newark who came to the Medical Society of New

Jersey House of Delegates meetings, and just on a repeated basis asked for our support in getting the State of New Jersey to reimburse the physicians better in the office. They were sending them to the hospitals where it was costing more. I think they thought everybody was going to run a Medicaid mill at that time. So this poor gentleman is now deceased, but this business of having them go to the hospitals has really boomeranged. The payments in the office are so terrible that you can't run an office for what the State is paying.

MR. MONIHAN: My clinic rate is $100 a visit.

ASSEMBLYMAN COLBURN: Also, another thing about Medicaid patients -- and this is off the subject, but -- they do not look after themselves as conscientiously as other patients, and their rate of broken appointments in our office is about three or four times what it is of any other group. So there is a whole huge problem of how you deal with folks that have trouble dealing with themselves. But that's off the subject. Any more questions?

MR. MONIHAN: No, I appreciate your--

ASSEMBLYMAN COLBURN: Anybody else wish to-- And you can rebut me after I close this thing. I'd like to thank you all for lasting as long as you did and contributing as you have.

ASSEMBLYMAN FRELINGHUYSEN: Could the Chair recognize Dorothy Powers? She wears a lot of different hats. I'm not sure what they all are, but they're important. She also chairs the Uncompensated Care Trust Fund Advisory Committee, and I'm sure she's -- I won't say relished her participation here today -- but certainly we've touched on some of the very things that you've been developing. And don't view this discussion of this particular bill as any attempt to divert the Committee from our expressed purpose and charge. I certainly continue to be committed to discharging our duties.

D O R O T H Y P O W E R S: (from audience) That's very reassuring. Thank you.

ASSEMBLYMAN COLBURN: I remember meeting you now at the session we had over at the-- Didn't we have a retreat that Commissioner Goldstein convened, and I think you were there at the time? I remember meeting you. I apologize for not remembering that.

The reason I held this public hearing really at this time was that we seemed to be getting so-- I didn't see any movement towards something that was supposed to end at the end of the year, and I guess I got slightly panicky over it. So, I hope this helps to precipitate further activity on all our parts, and we'll try not to do anything that's totally unfair in this Committee, toward anybody.

Thanks for coming. At the appropriate time I guess you'll tell us what you have to say, maybe not today.

MS. POWERS: Well, as a member of the -- chairing the Advisory Committee, by legislation we actually send our recommendations to the Commissioner. I think it's more appropriate for a commissioner to testify, so that is why I did not request-- (inaudible)

ASSEMBLYMAN COLBURN: Okay. Well, thanks very much. And we'll close the public hearing right now. Thanks again. The record is kept open for 30 days, however.

(HEARING CONCLUDED)

Uncompensated Care in New Jersey

The State of New Jersey has reimbursed hospitals for their uncompensated care since 1979. Although the process has been modified over the 9 year span, there have been several fundamental keystones of our system which have remained constant:

o ACCESS TO CARE: What does access mean to people in New Jersey? Access means that when you are sick and need hospital care you can go to any hospital and receive care regardless of your ability to demonstrate that you can pay for that care or that you have health insurance. We have a system in which all residents of New Jersey who need hospital care, but cannot afford the cost, can get it. The success of this program has been confirmed by the absence of reports in the newspapers of patient dumping and of hospitals refusing to treat or admit patients who cannot pay for their care. This has been confirmed again by the Robert Wood Johnson Foundation which found that residents of New Jersey had better access to health care than those from other

states. This ability to get needed care was particularly high for minority groups.

o **FULL REIMBURSEMENT: What does full reimbursement mean to people in New Jersey? It means that hospitals which provide care to people in need are guaranteed that they will be paid in full for the services that they have provided. This eliminates the incentive of hospitals to "dump" patients and it has allowed New Jersey acute care hospitals to remain in good financial health, as other hospitals across the country have closed their doors or sent the uninsured away without needed care. We have a system which allows hospitals to bill and collect 100% of their costs and which pays them as much for their uninsured patients as for those who are insured.**

o EQUITY AMONG PAYERS: What does equity mean to the people of New Jersey? It means that we have a system that spreads the cost of uncompensated care across the broadest possible base. We have a system which has maintained balance among those who pay for care. These costs are reviewed and approved by the Rate

Setting Commission.

In New Jersey the costs of uncompensated care are borne by the 89% of New Jerseyans who have health insurance. This broad base of payment minimizes the cost of paying for uncompensated care to any one individual.

We need an uncompensated care system because so many people in our society have no health insurance. This is the ROOT PROBLEM that we face. Over 15% of U.S. citizens have no insurance. Who are these people? They work in small businesses or are self-employed and cannot afford the costs of health insurance. They are uncovered dependents of people who have health insurance. They are those who fall just above the Medicaid income threshold and do not have the financial resources to buy health insurance. They are those who are unemployed.

In New Jersey we do much better than the nation as a whole- but still not well enough. 843,000 New Jerseyans or 11% of our State's population are uninsured- and this despite extremely low unemployment and a very healthy economy over the past few years.

In the past, if you were employed you could reasonably assume that you would enjoy the benefits of good health care insurance that would be provided to you and your family through your employer. As a result of a variety of changes which have affected our economy we have found ourselves with a very large group of New Jerseyan's who are employed but uninsured. The numbers may surprise you-- it is as high as 45%. An additional 30% are the spouses and children of these working uninsured.

When you passed the Uncompensated Care Trust Fund Legislation 2 years ago, you mandated that we look for alternative mechanisms to fund and provide uncompensated care. We have done so. I have assembled a broad-based Steering Committee on Health Care for the Uninsured which includes representatives from business, governmental agencies, health insurance, the hospital industry, and consumers to help me and my staff evaluate our system and to give advice on methods for improving our system. You set up, as part of the Trust Fund Legislation, a Trust Fund Advisory Committee, which includes representatives

from the New Jersey Business and Industry Association, The New Jersey Chamber of Commerce, Blue Cross, commercial insurance companies, the New Jersey Hospital Association, consumers, members of the Legislature, representatives of the Executive Office and other state agencies, to make recommendations to me on the future of the Trust Fund. We have consulted with national experts to elicit advice and to explore policy options and alternatives. We have met with key interest groups in New Jersey to discuss their concerns and we have completed an extensive report in which we have summarized all of this information.

There is a remarkable consensus among the groups I have just mentioned who serve on the Advisory Committee about next steps concerning the Trust Fund:

1. The Trust Fund should continue.

2. Hospitals should continue to receive full reimbursement for uncompensated care that they are providing.

3. The rate setting system should remain intact. It keeps the cost of care from rising more than necessary.

4. Stringent audit and cost control measures exist. These need to be strengthened to ensure that uncompensated care costs do not increase more than necessary.

5. Our colleagues in local medical assistance and county welfare programs should be challenged to optimize the number of people eligible for Medicaid and General Assistance.

6. We must increase the availability of affordable insurance- particularly among small employers where we find the largest percentage of the working uninsured. In addition, I strongly support the concept of Assembly Bill 3179, sponsored by Assemblyman Frelinghuysen, which would require college students to have health insurance. It is through these and other such mandates that lifelong patterns of purchasing health coverage can occur.

We are all in agreement that New Jersey should continue to pay for uncompensated care. The question of how uncompensated care is financed is what we are here to talk about today.

New Jersey should feel proud that it has taken such a

significant step towards solving a problem that is a deepening national crisis in health care. We are the only state that currently has a truly effective and successful system for assuring payment for care provided to the uninsured.

We finance this cost through add-ons to hospital rates. This means an increase in health insurance premiums. Medicare will no longer pay a share of uncompensated care. Therefore the amount of this add-on will increase.

There are three broad possibilities for financing uncompensated care. They are: 1) the entire amount should be raised through hospital rates; 2) only a portion should come through the rates and the remainder raised from other sources; and 3) the entire amount should come from outside the hospital rate system.

Assembly Bill 3476, recently introduced to address the funding for uncompensated care for 1989-1990, causes me great concern. This bill would violate all the keystones of our approach to uncompensated care. It would give hospitals an

incentive to dump uninsured patients; it would leave many hospitals in a financial lurch with threatened bankruptcy; and it would make the system dependent upon an unstable source of funding: general revenues.

As you are aware, hospitals in New Jersey are required by law to be paid in full for services rendered to patients regardless of the patient's ability to pay for the care received. I strongly support imposing rigorous billing and collection procedures to ensure that hospitals collect as much of a bill as a patient can pay. Last week, in fact, our rule making body, the Health Care Administration Board, adopted a set of regulations that tighten our controls over this area. This is necessary to make sure that hospitals do not write off patient bills to uncompensated care without strenuous efforts to collect from people who could pay.

But A3476 would substantially reduce payment to hospitals below what it costs to provide the care. This is not good business practice, and it is not good health policy. It will

create a downward spiral of payment below true costs that even the best managed hospital will not be able to recover from, and it will keep people who need hospital care from receiving it.

A suggestion has recently been advanced by the New Jersey Business and Industry Association to use a mechanism similar to the Unemployment Insurance Trust Fund to finance uncompensated care. This approach could take some or all of the costs of uncompensated care out of hospital rates and thus either totally or substantially reduce the add-on. One benefit of this approach is that it would proportionately distribute the cost of uncompensated care among all who pay Unemployment Insurance; not just among employers who currently provide health insurance for their employees, as our current system does. My staff is currently exploring this option and when, and if, it continues to show promise, we will discuss the proposal with the Trust Fund Advisory Committee and with you.

It is imperative that together we find a way to continue the Trust Fund through new legislation. If we are unable to

achieve this we will be forced, by law, to revert to the system that was in place prior to the enactment of the Trust Fund. That approach caused significant problems which in turn necessitated the creation of the trust fund mechanism. Under the old system, each hospital had its own uncompensated care add-on. This meant that a hospital that had substantial uncompensated care had a high add-on (and therefore higher bills for patients with insurance).

Should this be allowed to happen again, the hospitals which we most rely upon to provide care to those in need would be the very hospitals that would be most drastically affected. Insurers would avoid them because of their exorbitant costs. These same hospitals would soon be forced to close down or, as in the past, be bailed out by special funding from the Legislature on an unpredictable and sporadic basis. We will not be able to ignore these cries for help, nor would you even consider it. No one wants this situation especially because it would remove one of the major benefits of our current system, that is, the ability of

hospitals and the State to conduct solid financial planning.

All New Jerseyans currently have access to hospital care. All hospitals receive full reimbursement. Everyone shares equally in the system. We don't want this to change.

We have welcomed the cooperation of the Legislature, the New Jersey Hospital Association, and most importantly the payers of uncompensated care. I look forward to working with all of you to continue to ensure equal access to care for all residents of the State, full reimbursement to hospitals to ensure their fiscal stability, and to provide a stable funding source for uncompensated care.

Trust Fund Calculations, 2nd Half 1988

	Approved Collections	Approved Uncomp Care Costs	Uncomp Care Collections 10.5%cap	Uncomp Care Collections 7.0%cap
HACKENSACK	116,043,076	8,962,530	11,229,197	7,495,638
NEWARK BETH	117,959,051	14,435,283	10,856,209	7,246,664
PALISADES	26,633,265	3,144,362	2,463,207	1,644,223
HUNTERDON	29,624,882	1,924,951	2,904,804	1,938,995
SAINT MARY	28,621,341	3,934,025	2,588,881	1,728,112
HOLY NAME	64,396,216	2,890,108	6,449,951	4,305,428
CLARA MAASS	53,446,782	3,708,860	5,215,858	3,481,655
M.C. AT PRINCETON	35,920,297	1,380,891	3,622,038	2,417,758
BURDETTE	27,940,068	2,314,973	2,687,222	1,793,757
VALLEY	69,684,285	2,459,201	7,049,681	4,705,756
IRVINGTON	18,149,001	1,210,929	1,776,242	1,185,665
COOPER MC	104,429,766	12,678,887	9,621,624	6,422,562
MORRISTOWN	84,969,121	4,742,656	8,413,095	5,615,853
CHRIST	48,672,744	4,760,134	4,604,976	3,073,883
CHILTON	38,413,201	1,565,891	3,864,061	2,579,312
ST. JOSEPHS	91,361,992	15,776,431	7,926,418	5,290,989
BETH ISRAEL	35,153,357	2,702,970	3,402,969	2,271,527
ST. FRANCIS	52,871,358	6,488,058	4,864,070	3,246,831
WEST JERSEY	104,409,532	10,604,141	9,837,074	6,566,377
RAHWAY	41,238,955	1,665,363	4,149,957	2,770,151
BAYONNE	31,821,192	2,672,434	3,056,738	2,040,413
BARNERT	35,866,417	5,006,149	3,236,218	2,160,219
ELIZABETH GENERAL	54,677,164	10,331,649	4,650,374	3,104,186
NEWTON	23,372,838	2,601,031	2,178,274	1,454,026
LOURDES	55,581,412	5,205,055	5,282,809	3,526,345
DEBORAH	39,181,825	4,656,580	3,620,553	2,416,767
MILLVILLE	15,726,146	843,057	1,560,742	1,041,816
ALEXIAN BROTHERS	36,784,351	2,316,263	3,614,559	2,412,766
RIVERVIEW	62,090,979	5,180,816	5,967,988	3,983,711
SOUTH AMBOY	17,300,959	2,572,917	1,544,483	1,030,963
PASCACK VALLEY	40,246,076	1,538,142	4,059,178	2,709,555
RWJ UNIVERSITY	80,316,606	7,663,366	7,618,915	5,085,727
RARITAN BAT	56,723,077	10,082,334	4,891,067	3,264,852
ST. MARY	39,126,619	3,917,592	3,692,259	2,464,632
COMMUNITY	68,904,179	3,953,246	6,811,198	4,546,565
WEST HUDSON	23,346,224	1,607,474	2,279,674	1,521,713
MONTCLAIR	12,537,792	437,841	1,268,884	846,997
MERCER MC	44,780,384	4,066,077	4,269,580	2,850,001
ENGLEWOOD	73,376,237	4,965,565	7,174,010	4,788,747
SHORE MEMORIAL	45,832,697	2,963,995	4,495,505	3,000,809
SOMERSET	45,999,039	1,770,192	4,638,139	3,096,019
ST. FRANCIS	26,882,964	3,662,430	2,435,064	1,625,437
ST. CLARE'S	59,935,967	5,352,971	5,723,946	3,820,810
OVERLOOK	93,030,068	2,992,312	9,441,974	6,302,643
M.C. OF ORANGE	53,445,363	2,594,057	5,332,615	3,559,591
MOUNTAINSIDE	60,918,978	2,928,601	6,081,267	4,059,326
ZURBRUGG	58,550,397	3,220,222	5,802,300	3,873,112
MEMORIAL	54,945,626	3,689,189	5,375,100	3,587,951
BERGEN PINES	46,350,282	11,121,165	3,694,366	2,466,038
WARREN	27,034,651	1,179,095	2,711,390	1,809,889
UNITED HOSPITAL	88,872,211	12,814,603	7,975,920	5,324,033
MUHLENBERG	57,599,146	6,867,047	5,320,114	3,551,247
ATLANTIC CITY M.C.	91,090,350	9,561,579	8,549,664	5,707,014

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DOVER GENERAL	49,930,006	2,789,733	4,943,451	3,299,819
BRIDGETON	27,872,224	2,211,241	2,690,986	1,796,269
ELMER	10,939,041	718,722	1,071,772	715,422
ST. PETERS	67,104,914	3,933,875	6,624,547	4,421,973
ST. ELIZABETH	44,786,188	6,327,472	4,033,044	2,692,110
JERSEY SHORE	66,737,267	9,207,649	6,032,949	4,027,073
JERSEY CITY M.C.	75,368,789	16,182,660	6,206,662	4,143,029
MONMOUTH	83,947,014	7,491,479	8,017,650	5,351,887
ST. BARNABUS	112,756,763	4,377,581	11,365,381	7,586,543
PASSAIC GENERAL	54,366,179	3,768,538	5,306,014	3,541,835
HOSPITAL	42,601,212	4,687,248	3,975,917	2,653,977
UNDERWOOD	47,730,547	1,790,427	4,817,595	3,215,808
EAST ORANGE	28,468,939	5,700,503	2,387,654	1,593,791
KIMBALL	38,032,143	3,321,752	3,639,969	2,429,727
SADDLE BROOK	15,156,175	786,458	1,506,907	1,005,880
KENNEDY	80,002,838	7,170,822	7,637,663	5,098,241
NEWCOMB	27,906,552	2,103,419	2,705,893	1,806,219
KESSLER	16,686,399	1,053,930	1,639,327	1,094,273
UNION	26,819,933	1,196,342	2,687,065	1,793,651
SALEM	22,260,615	1,413,577	2,186,163	1,459,293
HELENE FULD	50,913,465	4,905,467	4,824,713	3,220,560
COLUMBUS	23,615,886	2,160,561	2,249,952	1,501,873
LIVINGSTON	8,662,892	671,685	838,013	559,384
CATHEDRAL	101,869,503	16,039,963	9,000,672	6,008,068
GREENVILLE	9,346,550	926,002	883,036	589,438
JFK COMMUNITY	59,574,037	3,268,390	5,904,595	3,941,395
HAMILTON	21,041,852	1,233,222	2,077,268	1,386,604
GREATER FREEHOLD	30,592,421	2,220,347	2,975,289	1,986,045
BAYSHORE	23,862,077	1,697,309	2,324,349	1,551,534
SOUTHERN	14,039,626	967,678	1,370,814	915,036
HACKETTSTOWN	16,495,531	1,315,423	1,591,890	1,062,608
WAYNE GENERAL	36,139,410	3,338,357	3,439,742	2,296,074
MEADOWLANDS	30,432,253	3,817,122	2,791,044	1,863,059
UNIVERSITY	116,945,586	14,755,297	10,716,372	7,153,320
WALKILL	9,686,198	617,151	951,042	634,833
			409,297,800	273,211,711

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NJHA NEW JERSEY HOSPITAL ASSOCIATION

at the Center for Health Affairs

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(609) 275-4000
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Louis P. Scibetta FACHE
President

TESTIMONY OF

LOUIS P. SCIBETTA, PRESIDENT
NEW JERSEY HOSPITAL ASSOCIATION

ON

UNCOMPENSATED CARE

TO

ASSEMBLY HEALTH & HUMAN SERVICES COMMITTEE
HAROLD COLBURN, M.D., CHAIRMAN

July 21, 1988
Trenton, New Jersey

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM LOUIS P. SCIBETTA, PRESIDENT OF THE NEW JERSEY HOSPITAL ASSOCIATION REPRESENTING ALL HOSPITALS IN THE STATE. THANK YOU FOR THE OPPORTUNITY TO ADDRESS TWO CRITICAL QUESTIONS:

HOW DO WE CONTINUE TO GUARANTEE THAT THE EVER-INCREASING AMOUNTS OF UNCOMPENSATED CARE PROVIDED BY OUR ACUTE CARE HOSPITALS ARE REIMBURSED TO THE DEGREE THAT THOSE HOSPITALS CAN REMAIN IN OPERATION?

AND, CAN WE CONTINUE TO RIGHTFULLY BOAST OF NEW JERSEY'S UNIQUE APPROACH TO HANDLING UNCOMPENSATED CARE WHEREIN PATIENT ACCESS TO CARE IS ASSURED-REGARDLESS OF THAT PATIENT'S ABILITY TO PAY.?

TWO YEARS AGO I TESTIFIED BEFORE THIS SAME BODY SUPPORTING THE CREATION OF WHAT SINCE HAS BECOME KNOWN AS AN INNOVATIVE AND NATIONALLY ACCLAIMED UNCOMPENSATED CARE TRUST FUND. THIS FUND HAS SUCCESSFULLY SPREAD THE COST OF INDIGENT CARE AMONG ALL THE 93 ACUTE CARE HOSPITALS IN THE STATE, WHILE DEMONSTRATING A PUBLIC AND PRIVATE SECTOR RESPONSIBILITY TO ITS POOR.

UNLIKE SOME STATES WHERE THE PRACTICE OF INDIGENT PATIENT DUMPING FROM ONE HOSPITAL TO ANOTHER HAS BEEN GRAPHICALLY DOCUMENTED, NEW JERSEY HAS HAD A PROUD TRADITION OF CARING FOR THOSE WHO CANNOT PAY FOR HOSPITAL CARE. THE MECHANICS OF THIS EQUITABLE DISBURSEMENT OF FUNDS, COMBINED WITH THE VERY FACT THAT THE LAW WHICH GAVE BIRTH TO OUR DRG SYSTEM DISCOURAGES DUMPING BY ESSENTIALLY GUARANTEEING PAYMENT, HAVE YIELDED A LEGACY OF CARING.

BUT NOW, ON A VARIETY OF FRONTS - BUT MOST DIRECTLY IN THE SHAPE OF ASSEMBLY

BILL 3476- THE FULL-FUNDING OF UNCOMPENSATED CARE IS IN JEOPARDY AT A TIME WHEN THE HOSPITAL INDUSTRY CAN LEAST AFFORD ANOTHER FINANCIAL BLOW TO AN ALREADY FRAGILE REIMBURSEMENT SYSTEM.

NO DOUBT YOU HAVE HEARD THE HOSPITAL INDUSTRY'S ARGUMENTS DURING THE LAST YEAR REGARDING THE UNDERFUNDING OF OUR REGULATED REIMBURSEMENT SYSYTEM. MEDIA REPORTS HAVE TRUMPETED SEVERE SHORTAGES OF HEALTHCARE WORKERS AND THE HIGH COSTS OF NEW TECHNOLOGIES, CARING FOR AIDS PATIENTS, PROTECTING OUT HEALTHCARE WORKERS FROM THE AIDS VIRUS, AND REMOVING AND DISPOSING OF HOSPITAL WASTE.

DESPITE THOSE FISCAL CHALLENGES, NEW JERSEY HOSPITAL CHARGES REMAIN AMONG THE LOWEST IN THE COUNTRY. SINCE I LAST APPEARED BEFORE YOU, EQUICOR CORPORATION, A CONGLOMERATE OF A FOR-PROFIT HOSPITAL COMPANY AND AN INDEPENDENT INSURANCE FIRM, SHOWS NEW JERSEY, WITH A DAILY PATIENT CHARGE OF $476, RANKING 49TH LOWEST IN A NATIONWIDE COMPARISON OF 1987 HOSPITAL CHARGES. THE FACT THAT NEW JERSEY HOSPITALS CAN KEEP ITS HOSPITAL CONSUMER COSTS SO LOW WHILE STILL MANAGING TO CARE FOR ITS INDIGENT PATIENTS IS A REMARKABLE ACCOMPLISHMENT.

BUT WE NOW FACE A TIME OF DELICATE BALANCE IN THE HEALTHCARE INDUSTRY. IT IS OUR CONTENTION THAT ANY OF THE PROPOSALS BROUGHT BEFORE YOU TODAY THAT WOULD DELETE DOLLARS FROM OUR ALREADY BARE-BONE REIMBURSEMENT SYSTEM WOULD SIMPLY RUB SALT INTO A WOUND. WITH ALL DUE RESPECT - MR. CHAIRMAN, MR. FRELINGHUYSEN, MR. FELICE- THE PROPOSALS IN A-3476 TO CAP UNCOMPENSATED CARE AT SEVEN PERCENT; TO DEDUCT THREE PERCENT FROM REVENUES EXCEEDING THE CAP; AND TO REQUIRE HOSPITALS TO ACCEPT THE MEDICAID RATE IN ALL EMERGENCY ROOM SITUATIONS WILL DRAIN THE LIFEBLOOD OUT OF THE UNCOMPENSATED CARE TRUST FUND.

THE RESULT? SUCH PROVISIONS WILL ONLY SERVE TO PUT MANY OF OUR HIGH

UNCOMPENSATED CARE HOSPITALS INTO BANKRUPTCY. HOSPITAL EXECUTIVES WILL SIMPLY HAVE TO TURN THE KEYS OF THESE BUILDINGS OVER TO THE STATE, WHILE SOME OF OUR HOSPITALS WOULD BE PUT IN A POSITION WHERE THEY WOULD HAVE TO LIMIT ACCESS TO CARE. I SUBMIT THAT NEITHER OF THESE ALTERNATIVES IS ACCEPTABLE TO THE HOSPITAL INDUSTRY OR THE PUBLIC. THE NEW JERSEY HOSPITAL ASSOCIATION CATEGORICALLY REJECTS SUCH AN APPROACH AND MUST VIGOROUSLY OPPOSE THIS LEGISLATION IN ITS CURRENT FORM.

INSTEAD OF CONSIDERING A CHANGE IN OUR SYSTEM THAT WOULD DENY ACCESS TO OUR HOSPITALS BY THE POOR AND NEEDY, WE SUGGEST THAT YOU LOOK TO ALTERNATIVE FUNDING SOURCES TO HELP KEEP THE EXISTING UNCOMPENSATED CARE TRUST FUND OPERATIVE. THE EXISITING FUND IS A UNIQUE AND SOUND APPROACH TO SHARING THE BURDEN OF UNCOMPENSATED CARE. IT HAS PROVEN ITSELF TO BE A GOOD SYSTEM FOR GOVERNMENT, BUSINESS, HOSPITALS, AND MOST IMPORTANTLY, THE PUBLIC.

ONE POSSIBLE APPROACH TO KEEPING THE FUND LIQUID WOULD BE TO ACCEPT THE RECOMMENDATION OF THE GOVERNOR'S UNCOMPENSATED CARE TRUST FUND ADVISORY COMMITTEE- EITHER DEVELOP A NEW TAX TO FUEL THE FUND , OR REDIRECT AN OLD ONE. CLEARLY, SUCH A BROAD-BASE TAX SHOULD BE CAREFULLY STRUCTURED AND POSSIBLY DIRECTED AT THOSE BUSINESSES THAT DO NOT ALREADY PROVIDE HEALTHCARE INSURANCE TO EMPLOYEES.

IN ADDITON TO SUPPORTING THE DEVELOPMENT OF BROADER-BASED FUNDING SOURCES FOR THE UNCOMPENSATED CARE TRUST FUND, I MUST MAKE ONE OTHER IMPORTANT POINT.

I'VE HEARD, AND I BELEIVE THAT YOU WILL HEAR TODAY, UNSUBSTANTIATED AND PREPOSTEROUS CLAIMS THAT HOSPITALS AREN'T DOING A GOOD JOB COLLECTING THEIR BILLS, HENCE CONTRIBUTING TO THE OVERALL HIGH UNCOMPENSATED PRICE TAG.

WE ARE CONFIDENT THAT OUR HOSPITALS BILL COLLECTION PROCEDURES HAVE BEEN THOROUGH AND DILIGENT, SO MUCH SO, THAT WE WOULD WELCOME ANY INTERNAL OR OUTSIDE AUDIT OF THAT COLLECTION SYSTEM. IN FACT, WHEN THE UNCOMPENSATED CARE TRUST FUND PROPOSAL WAS FIRST DEVELOPED, THIS ASSOCIATION STRONGLY SUPPORTED THE IDEA OF TOUGHER AUDITING PROCEDURES AS A CHECK AND BALANCE MECHANISM. HOSPITALS ACCEPTING UNCOMPENSATED CARE DOLLARS WOULD EMBRACE THE COMFORT THAT ANY STRICT AUDITING PROCESS WOULD BRING US AGAINST MISINFORMED CRITICS.

MR. CHAIRMAN, MY ALLOTED TIME HAS RUN. IN CLOSING LET ME REITERATE THAT REMOVING DOLLARS FROM THE CURRENT UNCOMPENSATED CARE TRUST FUND WILL ONLY RESULT IN LIMITING ACCESS TO CARE FOR THE INDIGENT OF THIS STATE AND POSSIBLY PROMPT THE FINANCIAL RUIN OF MANY OF OUR HIGH UNCOMPENSATED CARE CASE-LOAD HOSPITALS.

WE HOPE THAT THE LEGISLATURE WILL SEE FIT TO CONTINUE THE EXISITING UNCOMPENSATED CARE TRUST FUND, PERHAPS EVEN BOLSTERED BY A BROADER-BASED FUNDING SOURCE AND MONITORED BY STRICTER AUDITING PROCEDURES. TAKING DOLLARS OUT OF THE UNCOMPENSATED CARE PIPELINE WILL RESULT IN DETERIORATING THE HOSPITAL SYSTEM IN NEW JERSEY EVEN FURTHER AND WILL ONLY HURT THOSE WHO CAN LEAST AFFORD IT.

THE AMOUNT OF MONEY WE'RE SPENDING ON UNCOMPENSATED CARE OUGHT TO BE CONSIDERED A PREVENTIVE COST. IT IS <u>SOCIETY'S RESPONSIBILITY</u> TO <u>CONTINUE</u> TO INVEST IN DEVELOPING EFFECTIVE MEANS FOR PAYING THESE COSTS TODAY, SO OUR CHILDREN AREN'T FACED WITH AN UNSOLVABLE DILEMMA TOMORROW.

THANK YOUR TIME AND CONTINUED INTEREST IN NEW JERSEY'S HEALTHCARE DELIVERY SYSTEM.

NJSNA

609-392-4884

New Jersey State Nurses Association

Jean R. Marshall, R.N.
President

Barbara W. Wright, R.N.
Executive Director

TESTIMONY - PUBLIC HEARING

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

JULY 21, 1988

HOSPITAL UNCOMPENSATED CARE

320 West State Street, Trenton, New Jersey 08618

Access to hospital care is of major concern to the nursing profession. Statistics show that overall, New Jersey is better off than the rest of the country, since we have fewer uninsured. The reason seems to be more liberal qualification for medicaid and other state assistance programs. Strategies to increase insurance coverage include many creative ideas but probably the simplest and most realistic would be mandated employer provided health insurance. Costs would be born by the employer, shared with the employee or paid completely by the worker. However it is financed, this would become a fixed cost of doing business just as social security, disability and unemployment insurance are fixed costs. This approach would meet the needs of the working poor.

The problem of the unemployed or uninsurable will have to be addressed by the federal or state treasuries. The system presently shifts the burden onto insurance companies whose payments to hospitals are inevitably increased by uncompensated care. The New Jersey State Nurses Association supports spreading these costs out to society at large.

Solutions that call for cost effective measures are unfortunately entirely unfeasible as an answer to the millions of dollars being spent on uncompensated care. The present system of physician as gate keeper insures that less expensive professionals (mainly nurses) able to provide excellent care are denied the opportunity. State laws and regulations keep the poor and uninsured flowing through the "spare no expense" system of health care at a monumental cost. The irony is that cost has very little to do with many health care problems of the poor. Haphazard health behaviors and poor compliance are often the patient's main diagnoses. These problems are skillfully addressed by

by professional nurses.

In conclusion, the New Jersey State Nurses Association urges this committee to consider the impending crisis of AIDS when it suggests solutions to uncompensated care. Continuing the status quo will be unsupportable in the next ten years. Uninsured young people from poor neighborhoods are now at greatest risks for contacting AIDS. Their care will have to be managed as well as administered. Professional nursing is prepared and able to safely provide this care. We ask that you consider reducing the restraints on our practice so that we might be of service to society equal to our ability.

AWA/k

New Jersey
Business & Industry
Association

102 West State Street • Trenton, New Jersey 08608-1102 • 609-393-7707

STATEMENT OF

NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION

TO THE

NJ GENERAL ASSEMBLY

PUBLIC HEARING ON

POLICY ISSUES RELATING TO THE FINANCING OF HOSPITAL UNCOMPENSATED CARE

JULY 21, 1988

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Good afternoon, my name is Clyde Parker and I am Director of Manufacturing Personnel with Mannington Mills. I am appearing before this committee today representing the 11,000 member of the New Jersey Business and Industry Association. During the past 12 months I have served as a member of the New Jersey Uncompensated Trust Fund Advisory Committee.

The New Jersey Uncompensated Care Trust Fund (P.L. 1986, C.204) which was signed by the Governor on January 5, 1987, created a Trust Fund Advisory Committee. This Committee was charged by the statute with the responsibility of recommending to the Commissioner of Health alternative methods of financing uncompensated care. The statute also affirmed the surcharge (add-on) method to raise revenue for the Trust Fund and approved the Trust Fund concept for a two-year period. NJBIA supported the creation of the Trust Fund, while submitting that funding uncompensated care was a societal problem and urging increased funding from general revenues.

Analysis of the Department of Health's Efforts

The Trust Fund Advisory Committee held its organizational meeting in August, 1987, seven months after the law was signed. During the next several meetings, the Department of Health staff provided the Committee with a variety of background information on the magnitude of the financial problem facing the State's hospitals. This information enabled the Committee to comprehend the purpose of the Trust Fund as established and the direction given by the Legislature to the Advisory Committee.

A large amount of information was provided by the Department of Health staff concerning the demographics of the population who lack health insurance. Also, data was provided concerning the admission diagnoses of the individuals who have received uncompensated care. However, it is significant to note that,

despite requests, the Department of Health has been unable to provide demographic data on the profile of individuals whose hospital care resulted in the uncompensated care. The Trust Fund Advisory Committee was unable to learn what percentage, if any, of the total shortfall ($400 million in 1988) would be attributable to senior citizens, to single parents, to children, to the unemployed worker, or to the employed worker who had no children.

NJBIA submits that without this information it is extremely difficult to consider a realistic alternative funding method to the one which existed prior to the enactment of C. 204.

Despite a Department of Health regulation requiring hospitals to complete and submit a Uniform Bill-Patient Summary for every patient receiving hospital care for which the hospital receives no payment, hospitals are not consistently collecting information on the employment and insurance status of the patient or the person responsible for the bill. Furthermore, where the information is collected, it is not added to the Department of Health's data base on patient demographics. Had the DOH enforced its regulation, a great deal of pertinent data would be available. It also must be noted that hospital collection efforts are seriously hampered, when this vital data is not obtained. We fail to understand how the Trust Fund can properly reimburse a hospital for uncompensated care when it neglects to complete and submit the required forms. We strongly recommend that regulations be written to emphasize the importance of collecting this information from every patient and including it in a permanent database.

In the monthly meetings of the Advisory Committee a good deal of time was spent on exploring a variety of issues related to cost containment and alternative insurance programs. In the opinion of NJBIA, very little time was devoted to an in-depth discussion of the pros and cons of alternative funding methods. Two of the most obvious means for funding uncompensated care -- additional state

revenue through the Budget and specific tax increases -- have not been given any serious consideration.

Analysis of Hospital Efforts

Although the Trust Fund has had the positive effect of assuring hospitals reimbursement for uncompensated care provided, guaranteed payment can serve as a disincentive to collection efforts. Many of the hospitals neglect to follow Department of Health regulations. Why should they spend the effort when they will eventually receive 100% reimbursement for the services they provide to the indigent and others who do not pay for the care they receive?

Hospitals have not voluntarily sought to reduce the cost of administering medical care to those who utilize the emergency room instead of a doctor's office. Hospitals have not attempted to identify the individuals who neglect to pay their hospital bill. We have no idea of the mix, are they senior citizens, illegal aliens, the homeless or the poor? The record speaks for itself.

Due to the lack of identification on the part of the hospitals, their attempts at collecting bad debts are usually met with little success. We would suggest that hospitals review the identification procedures that a business or a bank utilizes before they extend credit for services rendered and modify the procedure to their operation. It has been brought to our attention that some hospitals that provide uncompensated care fail or neglect to obtain the proper identification of an outpatient. Why should they when the Trust Fund will fully reimburse the hospital!

Just because our law requires that all hospitals provide care to all individuals, regardless of their ability to pay, does not mean that complete identification is not necessary. We submit that hospital bad debt collection should be a priority for a hospital business office.

It has been suggested that in order to reduce uncompensated care, a percentage of funds that hospitals raise privately for capital construction should be used to reduce a hospital's bad debt and indigent care. The buyers of Health Insurance should not be required to pay for hospital construction in addition to indigent care and bad debts. This slight change would be an incentive for hospitals to keep their uncompensated care at the lowest level.

Alternatives for Funding Uncompensated Care

1. *State Programs to Deal With the Uncompensated Care Problem*

From a business point of view, programs for dealing with the uncompensated care problem fall into three groups: those that target providers; those that target individuals; and those that provide grants to local governments to purchase indigent and uncompensated care.

New Jersey utilizes a direct reimbursement through an all payor rate setting program. This type of program places the burden unevenly on employers who provide their employees with health insurance. Uncompensated Care is a problem that must be shared evenly by all taxpayers, not a small segment of taxpayers. NJBIA urges that the Legislature adopt an alternative to present method of uncompensated care. Therefore, we cannot embrace any program that targets providers, simply because this type of program would pass the burden on to the buyers of health insurance.

New Jersey is presently considering a program that would provide health insurance for the unemployed. This type of program is based on the assumption that health insurance is prepaid during periods of employment and when a worker is unemployed the new program would provide basic health insurance protection. This program will reduce Uncompensated Care caused by individuals

who have lost their health insurance as a result of unemployment or who can not afford to continue their COBRA insurance protection due to the high premium cost.

Another approach is to develop a program which will provide insurance coverage, either through vouchers to purchase insurance or as an expansion of an existing program (such as the Medicaid Medically Needy program) for those individuals who are currently uninsured. New Jersey has recently introduced this program on a limited basis and is currently correcting some administrative problems. We would suggest that this program be expanded to its maximum level because it includes some federal funding.

Another program worthy of consideration is direct government payments to benefit certain population subgroups. Under this option, New Jersey could develop a mechanism to provide direct subsidies to specific individuals who can not afford to pay for care. Under certain circumstances, this type of program could be cost-effective. An example of this program could be a special purpose program designed to provide access to care and financing for high-risk pregnant women. (the largest group of Uncompensated Care admissions). These programs could focus on any clearly definable population and could use cash payments, tax deductions, vouchers, entitlement programs or any other form of direct subsidy as the payment mechanism.

Options Available for Financing Uncompensated Care

There are several alternative methods for financing uncompensated care which are far superior to the present method. NJBIA urges the New Jersey Legislature to consider the following alternatives to the existing mechanism for funding uncompensated care.

1. Direct appropriation of state funds. The Legislature could appropriate funds directly to the uncompensated care Trust Fund in conjunction with other programs. This would be a feasible approach and could take the form of a line-item appropriation of funding for the state medically indigent program. We therefore urge support for A-3476 recently introduced by you Mr. Chairman and Mr. Frelinghuysen and awaiting consideration by this committee.

2. The Legislature should also consider amending the Constitution to earmark a percentage of State lottery funds and/or Casino revenue funds to the Uncompensated Care Trust Fund.

3. We also urge the Legislature to at least consider increasing the general sales tax and special purpose excise taxes on goods, such as alcohol and tobacco. The general sales tax could be increased by a small percentage or a special purpose use tax could be adopted. The concept of targeting "sin" taxes from alcohol and tobacco sales to fund certain health programs is not a novelty.

Conclusion

The above alternative options are not aimed at generating more money to cover uncompensated care, but instead seek to spread the burden more evenly in order to resolve a societal problem. NJBIA urges that legislation encompassing some of my previous suggestions be introduced as a package of bills to compliment A-3476.

Business in New Jersey cannot hope to survive in today's economy faced with escalating health care costs. The State must become intimately involved and take the lead in health care cost containment.

Chilton
Memorial
Hospital

Pompton Plains · NJ · 07444
201/831-5000

August 30,1988

David Price
Assembly Health Section
Office of Legislative Services
State Annex Building
Trenton,N.J.08625

Dear Mr. Price:

On behalf of Chilton Memorial Hospital, I object to Assembly Bill #3476 on "New Jersey Uncompensated Care Trust Fund". As a contributing hospital to the Trust Fund, we take pride in the fact that we have less than a 4% annual uncompensated care requirement. Our efficient procedures related to handling such accounts has resulted in zero (0) exception audits of our uncompensated care accounts for the past three (3) years. My colleagues in the major urban hospitals of New Jersey have the same goals for their uncompensated care procedures as I do. Unfortunately the matter is not controllable by them.

The health care system in New Jersey will not let the urban hospital centers suffer from lack of revenue. Under the present Trust Fund law, the efficient hospitals will be supporting the penalties imposed on the higher uncompensated care hospitals. Eventually many hospitals will not be able to support their debt obligations. Then the legislature will have to "bail out" the department because they have guaranteed the reimbursement for this debt.

I recommend that the findings and recommendations of the Governor's Uncompensated Care Trust Fund Advisory Committee be accepted.

Very truly yours,

S.Gilmore Stone
Vice President of Finance

SGS/mr

cc: J.J.Doyle
Craig A.Becker,NJHA

ASSEMBLY, No. 3476

STATE OF NEW JERSEY

INTRODUCED JUNE 27, 1988

By Assemblymen COLBURN, FRELINGHUYSEN and Felice

AN ACT concerning the "New Jersey Uncompensated Care Trust Fund," amending and supplementing P.L. 1986, c. 204, and making an appropriation therefor.

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

1. Section 6 of P.L. 1986, c. 204 is amended to read as follows:

6. For the periods beginning January or July of the hospitals' rate year, the department shall determine a uniform Statewide uncompensated care add-on. The commission shall approve the add-on before it is included in hospital rates.

The add-on shall be determined by dividing the Statewide amount of approved uncompensated care plus an amount adequate to repay any direct appropriation of State funds pursuant to section 12 of this act and to fund the reasonable cost of administering the fund pursuant to subsection a. of section 4 of this act and maintaining the reserve pursuant to subsection c. of section 4 of this act, by the Statewide amount of approved revenue for all payers and approved revenue for medically indigent persons less the Statewide amount of approved uncompensated care, except that the add-on shall not exceed 7%.

The add-on and any increases made to the add-on are an allowable cost and shall be included as part of the hospital's rates as established by the commission.

(cf: P.L. 1986, c. 204, s. 6)

2. Section 8 of P.L. 1986, c. 204 is amended to read as follows:

8. a. Hospitals required to remit the net difference of funds received from payers pursuant to subsection b. of section 7 of this act shall remit the funds in equal installments at the end of every month; except that a hospital shall make its first payment no later than 75 days after the fund is established.

b. If a hospital is delinquent in its required payment to the

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

trust fund, the commission may, pursuant to department regulations, remove from that hospital's schedule of rates the uniform Statewide uncompensated care add-on or levy a reasonable penalty on the hospital. The penalty shall be recovered in a summary civil proceeding brought in the name of the State in the Superior Court pursuant to "the penalty enforcement law." (N.J.S. 2A:58-1 et seq.). Penalties collected pursuant to this section shall be deposited in the fund established pursuant to this act.

c. Hospitals authorized to receive payments from the fund pursuant to subsection b. of section 7 of this act shall receive the payments on a monthly basis.

d. The commission shall adjust the schedule of rates for a hospital which is authorized to receive payments from the fund to reduce by a maximum of 3% the rate of reimbursement to the hospital under the diagnosis related group methodology established pursuant to P.L. 1978, c. 83, depending upon the amount of payments from the fund to the hospital and according to regulations adopted by the commissioner.

(cf: P.L. 1986, c. 204, s. 8)

3. Section 12 of P.L. 1986, c. 204 is amended to read as follows:

12. Prior to the expiration date of this act, the fund shall repay the State the total amount of any direct appropriations of State funds made to the fund pursuant to this act, except for the funds appropriated pursuant to section 6 of P.L. ..... c. ..... (now pending before the Legislature as this bill). The administrator of the fund, under the direction of the commission, shall develop and implement a procedure for receiving sufficient repayments so that the fund is able to repay the State as required pursuant to this section.

(cf: P.L. 1986, c. 204, s. 12)

4. Section 15 of P.L. 1986, c. 204 is amended to read as follows:

15. This act shall take effect immediately and shall expire on December 31, [1988] 1990.

5. (New section) The commission shall adjust a hospital's schedule of rates to ensure that services which are provided to emergency room patients who do not require those services on an

emergency basis are reimbursed at the same rate as provided by the Medicaid program established pursuant to P.L. 1968, c. 413 (C. 30:4D-1 et seq.) for services provided by a primary care physician in an outpatient clinic, according to regulations adopted by the commissioner. Nothing in this section shall be construed to permit a hospital to refuse to provide emergency room services to these patients.

6. (New section) There is appropriated $100,000,000 from the General Fund to the New Jersey Uncompensated Care Trust Fund for the fund's reserve required pursuant to subsection c. of section 4 of P.L. 1986, c. 204. Funds from this appropriation shall not be expended without the submission of adequate documentation as to the need for these funds to carry out the purposes of P.L. 1986, c. 204 and without the approval of the Director of the Division of Budget and Accounting in the Department of the Treasury, who shall consult with the Legislative Budget and Finance Officer prior to authorizing an expenditure of the funds.

7. This act shall take effect immediately.

STATEMENT

This bill extends for two additional years, until December 31, 1990, the statutory authorization for the "New Jersey Uncompensated Care Trust Fund" established pursuant to P.L. 1986, c. 204, which was to expire on December 31, 1988.

The bill provides an appropriation of $100,000,000 as a grant to the trust fund to cover its expenses during its extended period of operation. At the same time, the bill contains a number of provisions that are intended to encourage more efficient, cost-effective delivery of hospital care, as follows:

(1) The bill limits the uncompensated care add-on to hospital bills to 7%.

(2) The bill directs the Hospital Rate Setting Commission to adjust the schedule of rates for a hospital which is authorized to receive payments from the trust fund to reduce by a maximum of 3% the rate of reimbursement to the hospital under the diagnosis related group methodology established pursuant to P.L. 1978, c.

83, depending upon the amount of payments from the fund to the hospital.

(3) The bill also authorizes the Hospital Rate Setting Commission to adjust a hospital's schedule of rates to ensure that services which are provided to emergency room patients who do not require those services on an emergency basis are reimbursed at the same rate as provided by the Medicaid program for services provided by a primary care physician in an outpatient clinic. The bill specifies that a hospital may not refuse to treat these patients.

HEALTH

Health Planning and Costs

Extends life of "New Jersey Uncompensated Care Trust Fund" and appropriates $100,000,000.