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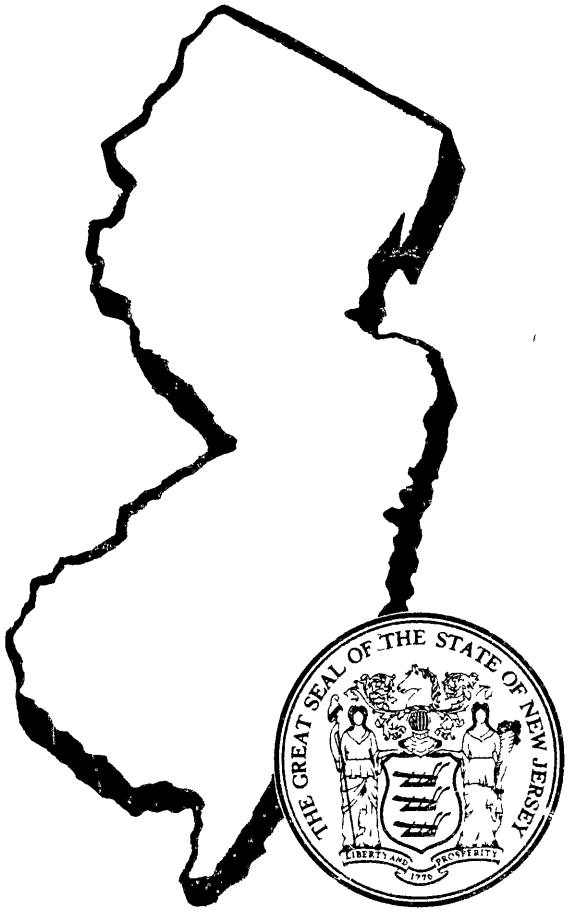
COST ACCESSIBILITY RESPONSIBILITY EFFICIENCY



FOR NEW JERSEY

Governor's Commission on Health Care Costs

Report Submitted October 1, 1990

EXECUTIVE SUMMARY

The crisis of health care costs is real, and is getting worse Nationally and in New Jersey, the costs of hospital care, doctor's visits and health insurance are rising at an alarming rate One million New Jersey residents have no public or private health insurance coverage For those with coverage, huge increases in insurance premiums have become routine Meanwhile, the uninsured have few options for care aside from hospital emergency rooms

The Crisis

In a remarkably short period of time, the cost of health care for businesses and individuals has gone from a relatively inconsequential nuisance to a major budget item Many New Jersey businesses are now forced to choose between health insurance premiums or jobs and wages Many are passing along to workers, for the first time, substantial costs of insurance Many others receive a 50 percent premium increase, and simply drop coverage

Many individuals face similar choices As astronomical rate increases arrive, New Jersey residents agonize over the choice of foregoing health care coverage or other essentials The human cost of this inflationary phenomenon can be devastating

The Commission believes that these cost increases have generated a cycle of cost escalation that must be broken As health care costs rise, some businesses and individuals become unable or unwilling to pay for premiums, or unable to afford the ever-growing deductibles and co-payments As people become uninsured, they are likely to obtain routine care in hospital emergency rooms through the Uncompensated Care system The Uncompensated Care Trust Fund is funded through a little known tax on all hospital bills As the amount of Uncompensated care goes up, the cost of health insurance rises, causing more people to become uninsured The cycle causes more and more people to lose health coverage, and consequently places a larger burden of payment on the shrinking pool of people who are covered

The people of New Jersey have long since determined that no one should be denied health care coverage on the basis of inability to pay Fiscal strains on the Uncompensated Care and Medicaid system, however, threaten the ability of the medically indigent to gain access to appropriate care, causing unnecessary suffering and, perversely, forcing them into higher cost health care settings

The cycle of higher costs and fewer insured can only lead to further crisis The Commission determined that solutions to this crisis can only be achieved if long-standing assumptions and barriers in the system are challenged This Report reflects that philosophy

The road to cost containment need not result in reduced access to appropriate health care Rather, there are many instances in which lower cost alternatives help improve access to health care The Commission attempted to take apart the pieces of the health care system, and put them together in a more functional configuration By moving from a fragmented, patchwork system toward a more comprehensive, unified system, both goals of cost containment and adequate access can be served

The Solutions

The Commission strongly believes that the logical conclusion drawn from the evidence presented is that a federal system of universal health care is necessary Such a system would most efficiently unify cost containment and full access If the federal government fails to act, the Commission recommends that New Jersey pursue its own universal system in the future The Commission believes that the recommendations that are made in this Report will significantly address issues of access, quality, cost containment, and the affordability and availability of health insurance for the majority of those who are currently uninsured

There are no perfect solutions

There are those who will say that we have not reached far enough, and others who will say our recommendations go too far With an issue as complex as this one, that is to be expected

This Report contains over 90 recommendations that are specific, targeted, and implementable Together they represent a comprehensive rather than piecemeal approach to the growing health care crisis in New Jersey However, much of the Commission's work may be lost in the vigorous debate that is likely to be generated by the recommendations surrounding the reform of the Uncompensated Care Trust Fund This would be unfortunate

This Nation is entering a period of economic uncertainty The slowing down of the economy is evident This economic pressure represents a compelling reason to address the oppressive costs of health care without substantial delay

The data regarding health care costs, most notably the Uncompensated Care Trust Fund, is lacking in several areas, flawed in others A year from now, we will have better statistics Are these better statistics likely to provide us with a major solution for which no money is needed -- or a series of choices quite similar, if not identical to those we face today?

The Commission concluded that the evidence dictated that this crisis should be addressed as soon as possible in as comprehensive a fashion as possible It does not make these recommendations unaware that they will, and should, generate debate Through this debate, an evaluation of this Plan, and the offering of alternative approaches and modifications, we, in New Jersey, can reach the consensus necessary to move forward together to resolve this crisis

The Commission, therefore, recommends the implementation of the following comprehensive 10-point plan

1 Reform hospital rate setting to set one fair, adequate, but final, rate per year Patients and insurers alike are harmed by the current system, that allows wide swings of rates during each year

2 Reform the health planning process Only facilities and services that are needed should be approved for construction, where they are needed. The containment of capital expenditures, through a yearly cap on approved projects, will also serve to reduce future operating costs by eliminating the construction or continuance of unnecessary facilities

3 Institute insurance reform to require community rating, limit pre-existing illness exclusion, and encourage primary care and wellness coverage

4 Expand Medicaid to the limits allowed by federal law, to permit full utilization of federal dollars for health care and enroll all Medicaid patients into a managed care system

5 Encourage managed care for all health benefits plans, to improve "well care" and reduce the cost of "sick care "

6 Split Blue Cross and Blue Shield to create a large-group entity, and a new entity dedicated to serving the public purpose of making insurance affordable to individuals and small businesses

7 Eliminate the existing tax on hospital bills, now approximately 17 - 19 percent, which adds hundred of millions of dollars to hospital bills each year

8 Institute a broad-based employer tax (1 percent on the first $14,400) of each employee's wages Charge employers who do not provide health insurance at a rate of $1,000 per employee

9 Apply the funds achieved through employer taxes and penalties toward providing residual uncompensated care and insurance subsidies

10 Increase the opportunities for individuals and small businesses to obtain insurance by creating a low-cost, basic managed care product, available either with or without a needs-based subsidy Create more opportunity for coverage through a Medicaid buy-in program and the new Blue Cross "public purpose" program

These points are fully described in this Report At its essence, the recommendation of the Commission is for uniting the disparate pieces of the health care delivery puzzle around the goals of cost containment and appropriate access to care for all We now provide care for all in New Jersey in an inefficient, haphazard and fragmented way If some tough choices are made, better care can be provided in a more cost-effective, equitably financed system

Introduction

OVERVIEW

The issue of rising health care costs are of nationwide importance The need for fundamental restructuring at the Federal level is obvious Between 1980 and 1988, the nation's health care bill more than doubled and now exceeds $600 billion each year Almost 12 percent of the nation's GNP is consumed annually by health care costs, putting both large corporations and small business at a competitive disadvantage in the world marketplace

At the same time, millions of working Americans are without insurance coverage while vast segments of the population, including the elderly and the poor, are inadequately covered

The national debate over health care cost containment has been the subject of numerous Federal and independent studies No resolutions have been enacted

Total health care costs in New Jersey are at least $17 billion annually and may be as high as $25 billion. Growth can be seen in many areas hospital costs, physician fees, the cost of drugs, medical technology, and the aging of the population The use of outpatient diagnostic and treatment services may be leading the trend, as both the use and cost of these services is rapidly increasing On the inpatient side, while the number of hospital beds has actually dropped, the total costs associated with them have continued to increase Meanwhile, the number of New Jersey physicians has continued to increase, having jumped by about 50 percent from approximately 10,000 in 1975 to over 15,000 in 1987 All of these cost factors impact the price of health insurance

Small businesses are the sector of the economy where the high cost of insurance hits hardest These companies with few employees have grave difficulties in finding insurance products they can afford to provide to their workers One survey of New Jersey small businesses has shown that 40 percent do not offer health insurance to their employees Thus with insurance costs spiralling, we are faced with a situation of working people and their dependents excluded from the benefits of health insurance

For the care of the uninsured, a tax of 17 percent to 19 percent is added to most inpatient hospital bills. Through the Uncompensated Care Trust Fund, New Jersey has made a commitment to care for those who lack coverage The money needed for the burgeoning ranks of the uninsured has also grown -- indeed, grown twice as fast as the overall cost of hospital care In 1990, this tax will collect and disburse $618 million to New Jersey hospitals through the Trust Fund, but will still not cover the entire costs of treating the uninsured in our institutions The rest of the costs will be recovered through the hospital's rates We already know that in 1989, the amount for uncompensated care budgeted by the Trust Fund was slightly over $500 million, while the actual amount of uncompensated hospital bills in that year exceeded $750 million Thus, we can only expect the demands on the Fund to continue to grow rapidly if nothing is changed

The tax to provide hospital care for those who are uninsured is paid by those who pay their hospital bills. Most of these dollars flow from individuals and business in the form of higher insurance premiums Additionally, the tax is not added to Medicare bills and Medicare's share is

instead shifted to the rest of those who pay for hospital care Only a portion of New Jersey businesses, those who purchase insurance for their workers, pay the lion's share of caring for the uninsured

The Uncompensated Care Trust Fund remains restricted to paying for care only in hospital settings. These acute-care institutions have assumed an increasing role in caring for the uninsured and the indigent due to the lack of available alternatives This is not the most effective mode of primary care delivery in terms of cost and continuity of care Hospital emergency rooms are not the best place for children with sore throats to be seen The use of community-based alternatives to hospital care has been given only limited attention by policy makers in New Jersey as a method to both restrain the costs of caring for the uninsured, and indeed to provide earlier, preventive care

The rapid rise in the health care costs is also based on our dependence on a fee-for service structure of health care delivery for most New Jerseyans. Such a system contains financial incentives for providers of health care to provide more services While managed care models have been shown to deliver high-quality care at lower cost, most New Jerseyans are still covered under traditional fee-for-service indemnity insurance policies

Programs designed to aid our neediest are also in dire need of reform Medicaid is the prime example The costs of this program have escalated sharply in recent years, with expenditures now exceeding $2 billion yearly Yet a shrinking number of physicians treat the growing number of eligible clients Fees for a primary care office visit are still at $14 Many of our low-income citizens are still not covered by Medicaid despite the availability of Federal matching dollars for expansion of Medical Assistance programs to cover more pregnant women and children **A promising experiment, in the form of the Garden State Health Plan, has shown that it is possible to provide reasonable payment to doctors, clinics and hospitals through a managed care system while maintaining access and controlling costs.**

Regulatory problems revolve around the lack of any cogent State Health Plan. Without such a plan, it has become increasingly difficult to decide where new services are needed and not needed in the State There is not always a link to any objective assessment of need When services develop where they may not be needed, the quality of care may suffer when practitioners do not have enough patients who can benefit from the technology's use Many people may be offered the service because it is available, not because they need it.

Under current regulations, many costly technologies, MRIs for example, are regulated for hospitals However, others can purchase and operate this equipment without any oversight. The result is the State is trying to regulate services by looking at only part of the picture Hospitals are held to a different standard than other providers

In health planning, there has been no overall determination of just how much the people of New Jersey should be spending statewide on costly capital projects Not only must we recognize and evaluate the spending necessary to build a new facility, but we must also be cognizant of the costs of operating this new service or facility for years after its acquisition or construction More attention must be directed to an analysis of whether New Jersey needs to build, rebuild, or renovate a facility, and whether it can afford to do so

In hospital reimbursement, a structure once designed to contain costs and to pay hospitals fairly for the services they provide has become a cumbersome, incomprehensible system riddled with exceptions and after-the-fact adjustments. In 1989, New Jersey hospitals filed over 1,700 appeals This number is projected to surpass 2,000 in 1990 Hospital bills include a number of surcharges and adjustments which can and do change many times during the year The complexity and size of such a system have exceeded the resources of anyone to manage it.

There is also some question as to how well costs are now being contained in the hospital setting **Total hospital costs have jumped 60 percent since 1983,** with increases now running at least 8 percent yearly In addition to the absolute level of costs, consumers and insurers have concerns regarding their predictability With the current system of monthly changes in hospital rates, insurance companies, business, and consumers cannot predict their expenditures on a yearly basis

The dilemma of health care costs is more complicated than it appears. All of the parts are interconnected, and the system must be viewed in its entirety. Addressing just one part of it can lead to dislocations elsewhere. Instead, a comprehensive approach is needed to address the problems of a health care structure for which we pay dearly, but which leaves many of our citizens out in the cold.

COMMISSION MANDATE

On April 19th, Governor Florio appointed the Governor's Commission on Health Care Costs and charged the Commission to closely examine the components of New Jersey's health care system as they related to the cost of and access to health care It was apparent that rapidly rising health insurance costs were a significant burden to both the business community and the labor force in this State with the potential to negatively affect New Jersey's economy, that the size of the uninsured population was increasing, rapidly approaching 1,000,000 New Jersey citizens, that the Uncompensated Care Trust Fund while affording access to hospital services was unfairly financed on the backs of those who had health insurance, that our current method of hospital reimbursement was overly complicated and burdensome to the hospital industry, regulators, and patients, and that New Jersey could not afford to wait for National solutions which did not appear to be forthcoming

To address these issues, the Commission was charged with the responsibility to recommend strategies to correct the excessive pressures on rising health care costs and to develop specific regulatory reform measures and marketplace initiatives to enable government and the private sector to better control cost increases

The nature of the problem, a complex interrelationship of regulation, cost and demand, pointed to the need for a broad, systemic review of all facets of health care delivery and financing Consequently, the Commission's mandate required a broad review of systems and options for change

COMMISSION'S WORK PLAN

The Commission members took the Governor's charge and challenges very seriously Members and staff received extensive testimony from individuals and groups on the problem and proposed solutions related to health care reform in New Jersey (Listing of testimony and documents received are included in the Appendices of this Report)

The Commission divided itself into five task forces in preparation for the second phase of its work plan These task forces were

Regulatory Reform
Reimbursement and Financing Reform
Health Delivery Systems
Insurance Reform
Uncompensated Care Reform

Phase I (Orientation and Analysis) included the time period from April 24th through June 26th and consisted of an intensive learning period with regard to New Jersey's regulatory, reimbursement, and financing system for health care The purpose of this phase was to provide each Commission member with the same level of detail regarding how the system works, what the stress points are, and to evaluate what is being done in other states to address similar problems During this phase, the Commission received and discussed myriad descriptions of the problem and suggested avenues for solution

During the months of June and July, the Task Forces held several meetings in which they reviewed information and data, received testimony on their specific topics, and discussed specific recommendations to be made to the full Commission These recommendations were presented to the Commission during Phase II of the Commission's Work Plan

Phase III (Refining the Plan and Preparation of the Report) included the two meetings scheduled for September and one additional meeting At that time, the Commission considered the entire package of recommendations, considered other items that had not been addressed, and prepared the Report for the Governor

CONCLUSION OF THE COMMISSION'S WORK

The Commission is proud to now present to the Governor its Report containing recommendations to improve both the access to and the costs of health care to New Jersey citizens

Included in the Report are several items that will require legislative action Several recommendations are expected to require administrative direction by the Governor to the government in order to effect the changes And, finally, some recommendations will require further development or action in the future All recommendations are preceded by the letters "CR" to designate "Commission Recommendation" and are sequentially numbered

The Commission has made every effort to consider the input of all who wish to be involved in this important process We believe this Report is a reasoned, responsible plan to improve New Jersey's health care system and to address the many aspects that have been making health care unaffordable to more and more of New Jersey's citizens

Universal Health Care

The need for universal health insurance has been argued periodically in the United States over the past 40 years The facts that millions of Americans have no health insurance, that this leads to poorer state of health for these citizens, and that simultaneously the US spends more money than any other nation for health care, all point to the need for a more comprehensive approach to health care financing

Various polls over the years have shown wide support in the American public for some sort of national health care program Gallup polls report that about 73 percent of Americans favor such a program This number drops slightly, to 67 percent, if the program is financed by additional taxes Only 30 to 35 percent indicate their support for a plan which restricts the insured's choice of physician Notably the greatest divisions arise over the issue of public versus private finance, with many favoring a system of compulsory employment-based insurance combined with public programs for those not in the work force

The Governor's Commission reviewed several models of universal health care in its deliberations including the Canadian approach, the Pepper Commission's recommendations, the Massachusetts plan and New York's UNYCARE proposal Clearly, the American health care system needs to move in the direction of universality with cost-control, and Canada's response as well as the other proposals are very promising in both areas

The current system in New Jersey, and the rest of this country for that matter, is fragmented Despite ever-increasing expenditures, more and more of the population is either under or uninsured For those who do have some access to care, that care is generally oriented towards treatment of the episodic illness, not life-long prevention Some, through Medicaid, are given access to a system with limited numbers of physicians willing to participate A universal plan can put all citizens on the same plane, with equal access to services It can also lead to a prevention and primary care-oriented framework, rather than one geared towards the maximum use of costly services

At the same time, health care costs in our nation are increasing at an alarming rate In a market with hundreds of private and public payers, it is impossible to form a unified front that will hold the line on costs The alternative model to the U S system is termed the "monopsony," and is in use in Canada and proposed in the UNYCARE model A single payer authority would replace the present multitude of paying parties, and that authority could bargain with hospitals, physicians and other providers using the leverage of size and unity Mostly as a result of this single payer authority and a stricter control on the regionalization of specialized services and equipment, Canada's per capita health care costs were $1,483 in 1987, compared to $2,081 in the United States

Under New York's proposal for universal health care for its residents, the single payer authority would guarantee payment to all providers All providers would deal with a single billing procedure The payer authority would in turn bill third-party payers and recoup any co-payments due This payer would negotiate reimbursement rates with all providers

An unemployment insurance surcharge of approximately 13 percent of the workers first $14,000 of wages would be levied on all employers not providing a certain level of health insurance All individuals with incomes below 100 percent of poverty would receive public insurance coverage From 100 percent to

200 percent of poverty such coverage would be subsidized Preventive care coverage would be extended to all individuals up to 17 years of age regardless of income There would be a standard benefit package including catastrophic coverage All New York State residents would carry the same universal enrollment card so all would be eligible for the same services and treated alike

To finance UNYCARE, the current $1 1 billion in statewide hospital bad debt and charity care expenditures would be redirected into insurance purchase The UNYCARE proposal contends that with the unemployment surcharge on employers who do not cover their workers and this $1 1 billion, little or no additional general revenues will be needed unless a small-employer subsidy for those newly offering insurance is included Such a "limited" subsidy is projected to cost New York an extra $250 million annually in general revenues

A universal health care plan can make the costs of health care visible and explicit Many businesses and individuals don't know how much they really pay for their own health care or for that of others Much of the cost is hidden, shifted, or otherwise obscured For instance, the Commission has repeatedly had to wrestle with the fact that few people in New Jersey understand that hospital uncompensated care is currently financed through a tax on hospital bills A universal health care plan can take all revenues and expenses into account By making these costs explicit some may realize that universal insurance plans don't necessarily raise total costs Instead, by making these costs apparent such a plan can help make cost-containment a reality

A system of universal care need not mean greater intrusion on the physician's practice of medicine, nor need it restrict individuals' selection of physicians and hospitals Indeed, with a single billing system and a single benefits plan, physicians would be freed from much of the work and confusion that now arises from having to manage patients under multiple billing systems and eligible for differing benefits The Canadian experience has succeeded in controlling costs even though patients are not restricted in their choice of physician

In the absence of discernible federal support, however, there are massive obstacles any single state would need to overcome on the way to universal health care The first set are raised by the Employee Retirement and Income Security Act (ERISA) of 1974 which prevents a state from mandating that employers provide health insurance This precludes the straight-forward expansion of our current employment-based insurance system that could be achieved by mandating that all employers offer insurance to all employees

In response to this, states have proposed "pay-or-play" insurance laws which would tax employers who do not provide insurance to their workers The tax would subsidize insurance for the uninsured while serving as a powerful incentive for employers to provide insurance rather than be taxed The Massachusetts Medical Security Act of 1988, which will be implemented between 1992 and 1994, includes such an employer tax of $1,680 per uncovered employee per year The New York proposal would assess $1,820 per year per uncovered employee

CR1. **The United States Congress should enact legislation within the next year for a Universal Health Care System to ensure that all Americans have access to quality health care.**

CR2. **Should the United States Congress not enact such a plan, the New Jersey Legislature should consider the passage of a Universal Health Care Plan that ensures that all New Jerseyans are covered through a single payer system and assured access to health care.**

Adopting a single state system of universal health care is a very difficult process and would require a series of waivers from the federal government These waivers would be difficult to obtain, and timely to pursue Given these facts, the Commission found that the situation in New Jersey could not be allowed to continue on its present course if and until such a national or state universal system could be achieved The Commission, therefore devoted much of its time to developing methods by which New Jersey could make immediate progress in alleviating the pressures that were causing its system to become more and more unaffordable to more and more of its citizens

The Commission adopted as its central problem statement in Regulatory Reform the need for a comprehensive health care planning process to determine the adequacy of existing services and the need for future services Related issues included the lack of a level playing field among all providers through the Certificate of Need process, low Certificate of Need thresholds, limited attention to the affordability of capital investments, and uncoordinated and limited participation of the citizenry in the health care planning process

Summary of Recommendations

Planning Reform

CR3. A State Health Plan should be developed and have the force and effect of State Law.

The State Health Plan would be revised annually and would give careful consideration to the input of the Local Advisory Boards regarding the specific regional and geographic considerations of access and delivery of health care services The purpose of the State Health Plan would be to identify unmet health care needs by service and location The State Health Plan would be the basis upon which CN applications are reviewed If the State Health Plan identified a need for a specific service in a given area, the Commissioner of Health would then through public notice, invite applications for the CN to satisfy the need If, however, the State Health Plan found that a given area of the State had sufficient capacity, the CN process would not be opened in that area for that type of service

As an example, if the State Health Plan determined that only Bergen and Ocean Counties had unmet need for long-term care beds, the Commissioner of Health would invite applications to satisfy that need in Bergen and Ocean Counties, alone Applications would not be accepted for long-term care beds in other counties in the State until, and unless, the State Health Plan determined that an unmet need existed Once sufficient certificates were issued to meet the need in the named counties, Bergen and Ocean, the CN process would be closed until additional need was identified Potential applicants who felt that the Plan was incorrect in the identification of need would submit their arguments and data through the planning process in an effort to have the plan revised For example, if an applicant in Burlington County felt, for whatever

reason, the Plan did not adequately consider special circumstances in Burlington County, or that the formula was not an accurate measurer of need, the applicant would make his case to the Local Advisory Boards and to State Health Planning Board during the course of the updating of the State health Plan The case could not be made ad-hoc through submission of specific certificates of need

This change would re-orient the regulatory process to be driven by health planning and not by certificate of need It would, as well, remove the potential for inappropriate or questionable intervention in the approvals or denials of certificates of need.

CR4. <u>The planning process should be governed by a new State Health Planning Board, an unspecified number of Local Advisory Boards, and a State Office of Health Planning within the Health Department.</u>

The Local Advisory Boards (LABs) would be the successors to the Health Systems Agencies They would have a stable funding source through State funds The purpose of the LABs would be to conduct planning activities within designated regions of the State and to make recommendations to the State Health Planning Board and the Commissioner of Health concerning planning issues reflective of local conditions The LABs would also conduct periodic certificate of Need review in accordance with the State Health Plan

In the initial year (1991), the State Health Department would be required to file a plan for the designation of local planning areas throughout the State To assure that health service areas are properly designated to reflect local health care patterns, population changes, and other relevant criteria, the DOH would undertake a review of existing boundaries for HSA regions This plan would be submitted to the Governor's Office and notify the presiding officers of the Legislature The Governor will subsequently designate the number and geographic boundaries of the LABs A permanent funding source would be identified and defined in State statute to authorize the creation and implementation of a statewide system for local and regional planning

CR5. <u>A State Health Planning Board should be established whose responsibilities would be the development of the State Health Plan in concert with the LABs and the State Department of Health.</u>

The State Health Planning Board would be the successor body to the SHCC In addition to its primary purpose for the development of the State Health Plan, the SHPB would also review certificates of need and make recommendations in accordance with the State Health Plan

The State Health Planning Board would include representation as follows

One representative from each of the Local Advisory Boards
The Commissioner of Health
The Public Advocate
The Commissioner of Insurance
The Commissioner of Human Services
The Chairperson of Health Care Administration Board
The Chairperson of the Hospital Rate Setting Commission
The Chairperson of the Public Health Council
Ten representatives appointed by the Governor

Staggered terms of office would be established and at all times the majority of appointed representatives must be consumers of health services who are neither providers of services nor who have any

fiduciary interest in health care services Included in the public members of the SHPB would be representatives of the business, labor, provider, and consumer communities The Department of Health should consider placing rule-making authority within the State Health Planning Board and/or combining the SHPB and the Health Care Administration Board (HCAB) into one body

CR6. Both the State Health Plan and each service regulation should be adopted by the Health Care Administration Board and have the force and effect of law. The State Health Plan would be re-evaluated each year and appropriate revisions made.

This allows the certificate of need process to be governed by the Plan and sets forth a course that is clear and measured in the growth of health care services and costs

Certificate of Need Reform

CR7. The State Certificate of Need activities should be directed by the State Planning process.

Once a need is established in the State Health Plan, the Commissioner of Health will invite applications to satisfy the need Applicants would be required to file applications concurrently with their regional LAB and the Department of Health The applications will be reviewed by the staff of the Department of Health and that staff analysis will be distributed to the LABs prior to their review of the application The LABs will be required to make recommendations consistent with the State Health Plan In other words, the LABs cannot ask for an exception to the Plan in order to approve services that are inconsistent with the Plan Should the LAB conclude that the Plan needs to be changed, that case must be made through the planning process

For example, let's assume that the State Health Plan determined that there was a need for 350 long-term care beds in Ocean County Once the Commissioner opened the certificate of need process to invite applications to satisfy that need, the Local Advisory Board would be compelled to limit the number of beds they recommend for approval to 350 If they perceived a need for 600 beds instead of 350, they would have to provide solid proof for amending the State Health Plan to recognize their need Only after the amendment was adopted and the Commissioner opened the process to recognize the need for 600 beds, would the Local Advisory Board be empowered to recommend approval of the 600 beds

The recommendations of the LABs are forwarded to the State Health Planning Board and to the State Health Planning Office The State Health Planning Board reviews the applications and makes recommendations in accordance with the State Health Plan under the same process as identified above for the LABs The recommendations of the LAB, SHPB, and the State staff are forwarded to the Commissioner

CR8. The Commissioner should review the applications and recommendations of the recommending bodies. The Commissioner is empowered to make final decisions on certificate of need approvals and/or denials if her decisions are consistent with the State Health Plan. An application which is denied has appeal rights to the HCAB.

Where the Commissioner of Health's findings and intended actions are contrary to the State Health Plan, she would be required to submit the entire record inclusive of the specific reasons for her intention to act contrary to the State Health Plan to the Health Care Administration Board who would have authority to make a final decision on the Certificate of Need application(s) in question If the HCAB agreed with the

Commissioner's findings and recommendations, it would direct the State Health Planning body to amend the State Health Plan to reflect its judgment and determination

As an example of the above, let us assume that the State Health Plan identified a need for 90 rehabilitation beds in a specific region and that five applicants filed CNs, requesting a total of 230 beds If the Commissioner determined that the approval of 90 beds would not provide sufficient access to care and elected to act contrary to the State Health Plan, she could not act on any of the applications in the batch Rather, she would submit her arguments for acting contrary to the State Health Plan as well as her recommendations for disposition of the applications in the batch to the Health Care Administration Board She might, for example, wish to approve 120 beds and deny 110 beds In such a case, she would be required to convince the Health Care Administration Board that the current State Health Plan did not adequately reflect need in the area in question If the Board supported the existing Plan, therefore not being convinced of the Commissioner's arguments to act against the Plan, the batched applications would be returned to the Commissioner for approval of no more than 90 beds If, on the other hand, they agreed that the State Health Plan did not adequately reflect need in the subject situation, the Board would direct the Planning process to amend the State Health Plan accordingly The HCAB would then act on the batched applications in accordance with the Commissioner's determinations The actions of the Board would be final subject to direct appeal to Superior Court.

CR9. As regional recommending agents on matters related to Certificates of Need, the LABs should not have an appeal right should the Commissioner act contrary to their recommendations. Only the State Health Planning Board, the applicant and other parties of standing would retain the right to appeal the Commissioner's determinations. The State Health Planning Board, representing the public process, could appeal the Commissioner's decision through the Administrative Law procedures, thereby establishing a separate record to be presented to the HCAB or to the courts. In such case, the State Health Planning Board would be represented by the Public Advocate, subject to the determination by the Public Advocate that the appeal has merit and is in the public interest.

For example, using the same case as above, if the Commissioner were to determine that the 90 beds to be approved were CNs 2, 3, and 6, and the LAB or SHPB had recommended 90 beds consisting of CNs 1, 2, and 4, the SHPB would discuss whether they wished to appeal the Commissioner's decision This appeal might be based on a difference in interpretation of the State Plan or a determination by the SHPB that the issues involved were of sufficient import to warrant an appeal The SHPB would then present the issue to the Public Advocate who would represent the SHPB in the appeal process subject to his determination of the merits of the appeal

Applicants who are denied in favor of another applicant would retain their right to appeal as exists under the current process

Certificate of Need Applications

CR10. The definition of a health care facility should be changed to include under certificate of need requirements any services which is the subject of a State-adopted health planning regulation or any service or acquisition with a total project cost exceeding $1 million.

Currently, only a limited number of health care providers are covered by State planning regulations To effect cost containment, the definition of a health care facility must be broadened so that all providers compete on a level playing field

CR11. The Certificate of Need thresholds for major movable equipment and for modernization, renovation, and new construction will be raised to $1 million with an annual adjustment for inflation.

This would allow routine purchases to proceed without Certificate of Need review and allow the resources of local and state planning bodies to remain focused on more significant projects

CR12. There should be an annual cap on capital projects.

For example, in a period of 11 months, the Health Care Facilities Financing Authority has or is scheduled to issue almost $1 billion dollars in hospital bonds for capital projects and refinancing A major determinant of the rise in health care costs includes the amount that the insured are paying for bricks and mortar The system must set a yearly level of affordability against which all requests for capital expenditures must be measured

The annual cap level would be established for a period of five (5) years and will be contained in the State Health Plan If, for example, that level is set at $200 million per year, the regulatory system must ration its expenditures among competing projects each year so as to cause no more than $200 million to be approved on major capital projects per year

CR13. The Department of Health should conduct a review of the statewide plant conditions and develop categories of priority against which capital expenditures will be judged. This analysis will be reviewed by the planning process and incorporated in the State Health Plan.

For example, a hospital that is in 1990 issuing bonds to rebuild its entire physical plant would be expected to end up as a very low priority for capital projects over the next several years On the other hand, a hospital that has 1950 and 1960 vintage buildings, with significant licensure problems, and beds that are unable to be used but needed, and with debt capacity, would end up as a high priority If the annual limit were $200 million, the second hospital would clearly be a higher priority expenditure This forces the system to consider overall affordability, and for capital projects to be judged based on their relative need in accordance with other capital projects It, therefore, ends the current practice of assuming an unlimited affordability for capital investment Hospitals would be included in the development of the information and analysis

CR14. In order to allow sufficient time to develop the above, and to eliminate a potentially counterproductive window, the capital batches scheduled for January 1, 1991 and July 1, 1991 should be eliminated.

This will allow the regulatory process to complete the re-evaluation of physical plant needs statewide and allow a better review of Certificate of Need applications for major capital expenditures

CR15. The Department of Health would have the authority to decertify paper beds based upon the utilization of those beds over time.

For example, if a hospital is licensed for 400 beds, but over the past two years has only staffed and operated 350 at 80 percent utilization, the Department would have the authority to amend the license of the hospital to reflect 350 beds

Likewise, if the State Health Plan showed an underutilization of beds in a hospital or service area that continued to show a downward trend, the Commissioner would have the statutory authority to reduce the hospital's license for such beds to the level which would allow the hospital to comply with identified utilization standards On a yearly basis, the State Health Plan would identify those hospitals and services which fail to meet utilization standards, and/or are experiencing significant financial or licensure problems These hospitals would be placed in a Special Monitoring Category The staff of the State Health Planning Office would develop a team whose charge would be to assist the hospital in developing a plan to bring it within utilization standards, correct its financial situation, and/or correct its licensure problems Such actions could include a recommendation to the Commissioner to reduce the hospital's licensed capacity, to examine options for merger or phasing out of all or part of the hospital's acute care services, or other appropriate actions that meet the needs of the population in the hospital's service area The goal would be to adjust the services to meet the actual needs of the population, to reduce overcapacity, and to discourage the unnecessary expenditure of additional health care dollars

CR16. Each certificate of need issued should have a discrete period of time for implementation.

For example, if experience shows that it takes an average 2 5 years to implement a certificate of need for rehabilitation beds, then as part of the State Health Plan that time would be identified as the life of the certificate of need If, on the other hand, outpatient services can realistically be implemented in 1 year, that would be the life of that CN

Certificates of need that are not implemented within the regulatory time frame would expire

This eliminates the bureaucratic paper work of reviewing extensions of time after only 1 year when it is recognized that 1 year is not a realistic time frame

CR17. A Statute prohibiting any physician from referring to a service in which he, his partners, or his family have a fiduciary interest should be proposed.

In a Congressionally-mandated study of medical business practices, the United States Department of Health and Human Services found that when patients saw physicians who had a financial interest in independent clinical laboratories, they received 45 percent more laboratory services In order to contain costs, while ensuring that patients do not receive inappropriate care, it may be necessary to prohibit physicians from referring patients to services in which they, their partners, or family have a fiduciary interest While the federal government has enacted legislation in this area, it will apply only to Medicare patients referred to clinical laboratories

HEALTH CARE FINANCING REFORM

The Commission determined that New Jersey's Medicaid program was in need of review to address both cost and access issues The second major issue was the complexity of hospital payment system including the presence of various mark-ups and surcharges, incomprehensible patient bills, a cumbersome and retrospective rate appeals process The Commission was also concerned about the exposure of New Jersey's elderly increasingly burdensome out-of-pocket costs

Summary of Recommendations

The Commission recommends the use of managed care in the Medicaid program as well as for all public and private employees in their health benefits programs Sufficient incentives are needed to encourage people to shift from indemnity type and fee-for-service health plans to managed care, health maintenance organizations (HMOs) and preferred provider organizations (PPOs) Public and private employers should foster maximum use of wellness programs

The Garden State Health Plan should be expanded and private HMOs should begin participating in the Medicaid program The large number of persons without health insurance must be brought into the health delivery system in appropriate community based settings HMOs doing business in the State should be required to submit a plan on how they will enroll Medicaid members The Department of Human Services will formulate a five-year plan for a major managed care expansion within Medicaid, including phasing in mandatory enrollment in the Garden State Health Plan and other HMOs and managed care systems for Medicaid eligible, except for institutionalized persons, and for opening the Garden State Health Plan to participation of private small employers through a Medicaid buy-in

The Medicaid program and public and private employees in their health benefits programs need to expand the use of non-institutional services, such as home health and personal care, as a way to help contain costs and to maximize health services in the community Greater efforts must be made to increase physician participation in the Medicaid program and to foster increased use of school based health clinics and comprehensive community health centers

The Commission recognizes that many of these recommendations will require appropriate transition and planning periods for implementation

Medicaid Reform

CR18. Garden State Health Plan enrollment of Medicaid clients should be expanded using every means possible.

The Commission believes the GSHP has the potential to delivery high quality accessible care, moderate program costs, and increase provider participation It will also be able to increase reimbursement to selected providers in a controlled, cost-effective fashion

The Garden State Health Plan should be part of an effort that would see all appropriate Medicaid clients enrolled in a managed care plan by 1995 This would entail a multi-year phase-in of the Garden

State Health Plan and other managed care initiatives, as provider networks and administrative structures are developed The Commission realizes that major investments in planning, marketing and provider recruitment and relations efforts will be required for the Garden State Health Plan to achieve these goals The Department of Human Services will formulate a five-year plan detailing a major managed care expansion within Medicaid

CR19. Expansion of Medicaid eligibility groups should be tied into a managed care or case management environment.

To expand Medicaid to the optional eligibility groups without any attempt to manage the appropriateness of care or its costs would only exacerbate the existing inefficient Medicaid fee-for-service system which has experienced a 10 percent annual increase in expenditures since 1985 Any expansion of Medicaid should be linked with managed care or case management, such as the Garden State Health Plan, a preferred provider such as HealthStart, or a private HMO or PPO, However, since the development of a full managed care program requires a transition period, expansion of Medicaid eligibility to optional groups should not be delayed because of its significance in improving health care services

CR20. New Jersey HMOs should submit a plan on how they will accept and enroll Medicaid members.

Since managed care as practiced by HMOs has reduced hospital utilization and in some cases provided greater primary care services at lower costs than traditional fee-for-service and insurance indemnity type plans, these benefits should be shared by the public as well as the private sector By asking HMOs to submit a plan to enroll Medicaid eligible, the objective of expanding options for managed care services under Medicaid will be better achieved with a level playing field for HMOs

In New York, HMOs have been required to demonstrate a willingness to execute Medicaid contracts to obtain their Certificates of Authority Currently over 47,000 Medicaid enrollees are in HMOs in New York State, including over 25,000 in one HMO alone

The Commissioner of Human Services should report to the Governor one year after HMOs are required to develop such Medicaid enrollment plans, and indicate whether this voluntary strategy is successful

CR21. Medicaid will expand the use of alternative health care delivery sites and health professionals.

Alternative sites of health care delivery will be established, including the expansion of the current network of school-based centers These have the potential to provide not only health care access, but also a full range of psychosocial services to all the state's children A part of this expansion, a full evaluation of the outcomes generated by these centers must also be conducted

Home health care is another mode of delivery which must be expanded. It can serve as an effective alternative to institutional care Several waiver programs within the Department of Human Services have demonstrated both the efficacy and cost savings found in home health care These models must be expanded.

Whenever possible, the use of non-physician providers,such as nurse practitioners and physician assistants, will also be increased in a variety of service settings These professionals have the ability to deliver high-quality care at much lower cost Nurse practitioners have already been successful in the school-

based centers Physician assistants have practiced in a number of settings in 49 other states and should soon be able to practice in New Jersey The legislative branch of government should review the possibility of establishing separate licensure guidelines for both nurse practitioners and physician assistants

CR22. Reimbursement to selected Medicaid providers who demonstrate commitment to a managed care system should be increased.

Medicaid reimbursement must be increased if we are to have any sort of workable medical assistance program The current fee schedule is woefully inadequate

However, a simple across-the-board increase in fees may only serve to increase expenditures without leading to greater provider participation or better quality services A fee increase must only take place in the context of Medicaid managed care, with providers agreeing to the responsibilities of such an arrangement in return for greater payment. Furthermore, primary care providers (e g , pediatricians, family practitioners, obstetricians) should be targeted under this initiative

CR23. Other steps should be taken by Medicaid to encourage provider participation.

Reimbursement alone will not insure the viability of managed care Successful health maintenance organizations incorporate a number of features to guarantee some selectivity in choosing providers, to aid in recruitment, to maintain quality standards, and to respond to patient inquiries Medicaid will, as part of its managed care efforts, establish a formal system of provider relations and monitoring, and seek to reduce the administrative burden now facing Medicaid providers

CR24. County and/or State Medicaid workers should be placed on-site at community health centers and hospitals serving large indigent populations to facilitate eligibility determinations.

The current Medicaid eligibility process is very difficult for citizens to negotiate, and is not conducted on provider premises Every effort must be made to move the locus of enrollment to the most frequently used points of entry into the health care system For many, this means hat eligibility should be determined at the hospital site This will increase access to Medicaid, insure the state and its citizens receive their fair share of federally funded services, and cut inappropriate charges against the Uncompensated Care Trust Fund

In order to keep this as simple as possible, the state and counties should consider the use of on-site eligibility systems which do not require the stationing of an eligibility worker, but which can still lead to rapid on-site enrollment This would include the use of electronic data links between the hospital/community health center and county offices, to be used by hospital/center personnel in enrolling clients

CR25. The potential for immediate on-site eligibility determination should be considered. Presumptive eligibility should also be expanded. The eligibility and enrollment processes must be streamlined.

While the expansion of the use of presumptive eligibility should be expanded, other states now conduct full eligibility determinations at the hospital site This promises to cut the administrative complexity and burden of eligibility It would also obviate the need for a two-step process of presumptive determination followed by fully eligibility determination

The current Medicaid application process is extremely cumbersome, involving the use of a 16-page form Within the bounds of federal law, this paperwork should be reduced to an absolute minimum

CR26. The Garden State Health Plan should be used to provide health coverage for small employers and as a HMO option for public and private employees on a self financing basis.

Use of the Garden State Health Plan to provide a basic package of health care services for small employers and as an option for public and private employees should be fully explored as part of the overall managed care initiative and to help relieve the uncompensated care trust fund burden The Department of Human Services will formulate a plan to implement and phase in this objective as part of its five-year plan The Garden State Health Plan will be used to allow a low cost buy-in of a health benefits package for small employers and public and private employees This requires State legislation

The proposed initiative would provide small employers with the opportunity to purchase affordable health coverage for their employees through the Garden State Health Plan (GSHP) The basic strategy would be built upon the GSHP's existing network of providers and administrative structure to offer uninsured workers and their dependents a basic and affordable health benefit option not currently available to them in the private market

Two enrollment options could be available (1) a basic plan that covers inpatient services, physician services (primary and specialty care), prescription drugs, laboratory and x-ray services, and (2) a supplemented basic plan that covers podiatry, optometry, optical appliances, prosthetics and medical supplies, in addition to the basic plan A $3 00 co-payment was not included, but could be added to make the buy-in plan more financially attractive to the employer

The estimated premium schedule has been established to fund the projected costs of the plan The attached contains the approximate annual premium estimates for non-Medicaid enrollment in the GSHP

CR27. A "HealthStart Plus" program should be created using a two-tiered insurance approach to insure comprehensive medical and support services to pregnant women up to 300 percent of the poverty level.

One third of all hospital admissions covered by the Uncompensated Care Trust Fund are related to maternity The fact that so many episodes of childbirth are among the uninsured reflects larger problems in our State New Jersey continues to be challenged by the complex problems of lowering high infant mortality rates and reducing the incidence of low birth weight babies In 1988, there were 117,485 live births in New Jersey and in 1989, births were estimated to be 119,000 Currently, the low birth weight rate for whites is 5 4/1,000 and for non-whites 12 1/1,000, and the infant mortality rate for whites is 7 8/1,000 while for non-whites it is 18 0/1,000 The inability to narrow the disparity in infant mortality and low birth weight rates reflects a variety of socially complex factors including socioeconomic status, environment, life style and lack of access to needed health care services

This program would respond to these problems and aim to

* reduce poor birth outcomes

* reduce long-term morbidity and developmental problems among children born following improperly managed pregnancies

* reduce unacceptably high expenditures for technology-intensive care of sick or low-birth weight newborns, and for fragmented services provided to pregnant women without case management

* support the development of much needed community-based services

* focus not only on medical problems, but the accompanying psychosocial milieu as well

The first part of the program would provide expanded Medicaid eligibility for health and support services funded by 50 percent federal dollars and offered through the Medicaid-funded HealthStart program to women and children up to age 6 between 133 percent and 185 percent of the federal poverty level Recent legislation requires Medicaid coverage of pregnant women and young children up to 133 percent of the poverty level, and permits such coverage up to the 185 percent mark The new program would maximize the federal contribution to the costs of prenatal health support services and preventive pediatric services

The second part of the program would provide all women between 185 percent and 300 percent of the federal poverty level the ability to buy into the Garden State HMO for health support services for pregnant women and children up to age 6 The fee to buy into the program would be set by the Garden State Health Plan and would be low enough to ensure its affordability This approach would effectively assure the universal availability of such prenatal services for low-income people who are uninsured

Both parts of this proposal would provide poor pregnant women with nutritional counseling, guidance, home visits when necessary, and other educational and supportive services that help lead to healthy and high-birth weight babies In addition, both parts of the proposal rely on case management for effective and efficient coordination of services

In addition, the plan should include additional benefits intended to prevent future problems Access to certain services should be facilitated, including educational programs to give each participant a chance to obtain a high-school diploma or G E D , treatment slots for substance abuse, vocational training and family planning services Interdepartmental resources in state government should be pooled on a priority basis to provide these additional benefits Expanding the emphasis of this program beyond traditional medical services enhances its long-term benefit to mother and child, as the problems of inadequate prenatal and child care extend far into the spheres of education and family relationships

Medicaid Expansion

CR28 **The state should develop and implement a statewide network of managed care providers for the Medicaid program.**

At the same time, the state should examine whether it needs to also increase the existing fee schedule to a level sufficient to significantly increase the number of physicians treating Medicaid patients, especially children

CR29. **Legislation should be enacted which expands the Medicaid eligibility groups to include all optional groups for which federal financial participation is available.**

CR30. The state should explore and monitor on an ongoing basis additional categories for Medicaid eligibility under waivers from the Health Care Financial Administration (HCFA) or new legislation, and should expand the Medicaid program on an ongoing basis to maximize the use of federal funds.

CR31. Optional services provided under the Medicaid program should be reexamined for cost-effectiveness and necessity, and reductions or eliminations should made when appropriate.

CR32. The State should consider ways to expand home health care services.

The State of Indiana has requested a federal waiver to reimburse relatives of Medicaid eligible trained to provide homemaker and personal care services if providing the services creates a financial hardship for the relative Under federal law, personal care services provided by a relative are not reimbursable under Medicaid

CR33. The state should explore a federal waiver for the inclusion of wellness benefits in the Medicaid program.

CR34. The state should simplify possibly centralize the administration of the Medicaid program. Medicaid payments to providers should be timely made.

Community-Based Services

CR35. Comprehensive community health centers should be supported and expanded.

As a means of extending the network for health services, especially in underserved urban and rural areas, the State should encourage the growth and viability of comprehensive community health centers, especially since federal legislation, effective April 1, 1990, requires the centers to be reimbursed by Medicaid on a cost basis These centers are in ideal option for the poor in areas where access to physician office care is lacking A method needs to be developed to provide reimbursement to these centers for non-paying clients

CR36. Relationships between community health centers and hospital outpatient facilities should be established and nurtured.

Community health centers can provide quality, ongoing care to many New Jerseyans at lower cost than providing episodic care in hospital emergency rooms and outpatient centers With appropriate triage, many patients now seen in emergency rooms could be redirected to health centers functioning with expanded clinic schedules

At least one site in New Jersey serves as a demonstration of a primary care relationship between a hospital and a community health center The experience gained in this experiment can be used in designing additional arrangements which emphasize the advantages of using community-based services This will reduce use of the most expensive settings for many clients, while allowing our citizens to form more stable ongoing relationships with health centers which can provide greater continuity of care

CR37. Greater emphasis on the use of school-based health clinics should be made as a means of improving early disease prevention and health promotion for all children starting at the elementary school level.

The Department of Human Services is operating a school-based youth services program which offers a comprehensive range of services, including employment assistance, job development, drug and alcohol counseling, family crisis and academic counseling, recreation and health and social services With 29 sites covering 21 counties, the program is being expanded to several middle school sites While pursuing this objective, the Department of Human Services should evaluate the effectiveness of the use of school based centers for improving the overall health and well being of children and adolescents

The current program should be expanded using the school-based model and extended to the elementary level of education In reference to health care

(1) Demographic areas of greatest poverty and health needs should be targeted for the expansion of school-based health clinics to promote health education and disease prevention

(2) School-based health clinics should be linked with greater EPSDT (Early Periodic Screening and Diagnostic Testing) outreach and treatment programs funded by Medicaid

(3) Uniform standards should be established for school-based clinics with greater physician and school nurse involvement and emphasis on primary medical care The Department of Education is currently working on an expanded curriculum and should consider this area, along with expanding clinical and health care services At present, school nurse resources and requirements are restrictive and should be redefined However, this may be coupled with liability and legal issues

(4) Physician staffing should be provided by persons who participate in the University of Medicine and Dentistry of New Jersey State tuition aid refund program, as well as other community health centers

(5) A stronger relationship should be developed between school-based clinic staff and the health education department of the school

CR38. Reimbursement of uncompensated care should be extended to out-of-hospital settings.

The reimbursement of uncompensated care only in hospital-operated facilities will not lead to the provision of efficient primary and preventive services to the state's uninsured Similarly, it makes little sense to propose expanding such community-based services without extending reasonable reimbursement to pay for them

Uncompensated care dollars should begin to flow to community-based centers in a controlled and limited fashion through specific pilot programs, with opportunities to expand that flow should it be deemed appropriate Only then will uncompensated care become less of a hospital-fiance tool, and more of a fund to provide care to those who can least afford it

CR39. Greater use of ambulatory surgery centers should be encouraged in keeping with State health care needs.

Ambulatory surgery centers perform less complicated surgical procedures in a community setting at lower costs than the same procedures performed in a hospital setting The centers are subject to State licensure and inspection standards, but Medicaid procedures should be adjusted to conform with Medicare levels of surgical procedures Currently, Medicaid reimbursement is based on Medicare's four payment groups On March 12, 1990, Medicare revised their payment methodology from four to eight groups based on the complexity of the surgical procedure They range from minor procedures in Group 1 to major procedures in Group 8 Medicaid should change from four to eight groups for consistency as soon as possible

Hospital Rate Setting Reform

CR40. Benchmarks should be determined by which the financial performance and productivity of the health care system and specific hospitals can be measured in relation to the nation and our own expectations.

Currently there are no accepted criteria by which to judge our performance in cost-containment or productivity Other states have instituted certain target measures, such as expense per adjusted admission, to gauge whether their hospitals are becoming more or less efficient, and whether they are following national trends It is imperative that such measures be selected in New Jersey, and that such data be collected at least annually and published Data on hospital occupancy and utilization must also be collected and compared to both our own targets and national figures

CR41. Hospital rates should be set once a year.

Fluctuation in hospital rates on a monthly basis is unfair to consumers and insurers Consumers are often faced with paying dramatically more for a hospitalization in one month relative to another month Insurance companies are unable to project premiums for an entire year because they are unable to predict their hospital expenses

Hospital rates will be set once per year on a prospective basis Rates will reflect automatic adjustments and any other adjustments that result from statutes and regulations affecting the delivery of health care in one or more hospitals, taking into account the effectiveness and efficiency of the health care delivery system as a whole

CR42. An all-inclusive payment system should be implemented.

Much of the deserved criticism of the present DRG system is its complexity and incomprehensibility Instead of mark-ups and surcharges, we need to move to a single prospective rate for a single disease

To achieve this, indirect costs will be allocated to each DRG rate depending on the estimated legitimate presence of those costs in each DRG This will end the current highly inequitable system in which the indirect reimbursement is the same for a two-day admission for child birth as it is for a two-week admission for a heart attack The mix of standard versus individual hospital costs within each DRG will change to reflect the inclusion of indirect costs in the payment rate (see Recommendation #5, below) Capital costs will also be included in the rate

The current pass-through of certain costs, including collection agency costs, will also be terminated Pass-throughs essentially reimburse a hospital for whatever it spends, require eventual retrospective adjustments, and run counter to the principles of cost containment Collection costs should be reimbursed on a prospective basis

CR43. A target-defined automatic prospective adjustment of 2 percent of projected gross revenues should be provided to all hospitals.

Hospitals experience cost increases which cannot be captured in annual inflation factors, and which are beyond their control Some adjustment is also necessary to allow hospitals to build equity which can be used to finance necessary and appropriate projects This adjustment will replace the several currently provided adjustments in the reimbursement system, and will assume the establishment of adequate prospective rates The adequacy of the 2 percent adjustment will be reviewed after it has been in place 24 months This adjustment will not constitute a guaranteed operating margin

CR44. The use of "standards" (statewide averages) in calculating rates should be increased.

To calculate each DRG rate, both the statewide average costs of treating patients in that DRG, and each hospitals individuals costs of treating patients in that DRG, are used The mix of these two components has changed over the years, so that increasingly, each hospital's DRG rates are based less on the statewide averages (standards) and more on its individuals costs Thus high-cost, less efficient hospitals have their rates increased, while low-cost, efficient hospitals see rate decreases

The movement towards more of a standard rate has long been an unfulfilled goal of hospital rate setting The federal Medicare DRG system has achieved some success through use of its own highly standardized rates The amount of standard in New Jersey DRGs should be increased to encourage efficiency and cost containment.

To increase this proportion of standard, the following table will be used

DRG Coefficient of Variation	Proportion of Standard
0 - 19	100%
20 - 39	80%
40 - 59	60%
60 - 79	40%
80+	20%

NOTE The term "Coefficient of Variation" serves as a measure of the variation in the costs among all patients in the State with the same diagnosis

CR45. Better measures of case-mix to pay hospitals more appropriately should be utilized.

Many hospitals, especially those in inner-cities, report treating sicker and more costly patients Current DRG case-mix systems may not, for example, be able to differentiate between patients with the same diagnosis but different severity of illness For instance, it may cost more to treat a patient with severe pneumonia than a mild case, but our DRG system would pay the same amount for each

In order to differentiate between patients with varying severity and burden of illness, and to pay hospitals more appropriately on this basis, the newly developed Yale Refined DRGs should be considered as the measure of patient classification in New Jersey This system has the ability to capture these differences, and it will not pose a major new administrative burden on either hospitals or regulators Federal Medicare regulators are expected to also adopt a more refined DRG system in 1991

CR46. High cost and potentially insolvent hospitals should be identified.

Hospitals which either have consistently very high costs, or are in financial distress, will be officially identified The Hospital Rate Setting Commission will then work with those hospitals to develop plans for cost containment or return to solvency These plans will include a review of all available sources of revenue such as foundations and for-profit subsidiaries and suspension of all certificates of need

Further actions if a hospital remains distressed may include a reduction in the hospital's size, its merger with other institutions, or its liquidation This process will work hand in hand with health planning There will be no ironclad guarantee to protect the solvency of every hospital regardless of the need for that institution, its efficiency or its utilization

CR47. Methods to increase Medicare revenue collected by hospitals should be pursued more aggressively.

Evidence points to significant under-collection of Medicare dollars by New Jersey hospitals With the current shifting of 100 percent of the Medicare payment differential to non-federal payers, hospitals may have little incentive to collect every Medicare dollar possible To provide that incentive, less than 100 percent of the differential should be cost-shifted, leaving hospitals at risk for a portion of that amount

Additionally, hospitals should be allowed to keep at least a portion of Medicare overages in order to encourage them to aggressively pursue legitimate and deserved Medicare reimbursement.

CR48. The Hospital Rate Setting Commission should be reorganized.

Currently there is no true payer voice on the Hospital Rate Setting Commission Similar bodies in other states have business representation with very positive results As the major purchasers of health care, labor and business need to participate in health care payment decisions Insurance companies and other health benefit organizations are specifically excluded from this definition of a "payer "

After review of the current functions and composition of the Commission, it is recommended that a payer seat be created on the Hospital Rate Setting Commission, and that both the Commissioners of Health and Insurance be removed from the Commission Furthermore, it is recommended that the "public members" of the Commission should in reality represent the citizenry of the state, not just special interests Finally, the Public Advocate must play a more vital role with the Commission The Department of Health should examine the feasibility of placing rule making authority for rate setting only within the Hospital Rate Setting Commission

CR49. Reasonable reimbursement for hospital-based specialists should be rebundled into hospital rates, rather than the current practice of separate billing for these professional services.

Many hospital-based specialists (e g , pathologists, anesthesiologists, radiologists, emergency physicians, etc) now bill patients separately from hospitals In large part, this is due to Medicare regulations However, this can remove physicians from cost containment mechanisms The status quo is therefore inherently contradictory, with hospitals having an incentive to reduce the intensity and volume of services while specialists at those hospitals are paid under a fee-for-service method which encourages maximal utilization and high charges For non-Medicare patients hospital cost-containment should be extended to include more of the services provided in that hospital, including those rendered by these specialists

The task force is cognizant of the fact that rebundling will lead to an increase in inpatient hospital rates, but believes that overall real cost savings will be achieved as total hospitalization bills (including specialist fees) will decrease

CR50. A reform of the patient bill should be examined and implemented.

The current patient bill is extremely confusing Consisting of a jumble of numbers such as itemized charges, DRG rates and "payer factors," it is justifiably incomprehensible to the consumer Indeed, some may have no relevance to the consumer The bill must be understandable so that people know how much the owe

Hospital Rate Appeal Reform

CR51. A full review of a hospital's cost base should be required as part of an appeal.

The Courts have ruled that the Hospital Rate Setting Commission may hear a hospital appeal without consideration of the hospital's entire cost base This has helped lead to a situation where hospitals appeal hundreds of items without having their entire financial and cost experience reviewed The incentive for hospitals aims not at efficiency, but rather revenue enhancement through appeals and other adjustments

Clarification is necessary to return to the original intent of the full rate reviews as part of Chapter 83 statues regarding hospital appeals Changes in hospital rates other than automatic periodic adjustments and adjustments for statutory or regulation changes will require a full review of the hospital's preliminary cost base or certified revenue base This review will take into account all hospital affiliated organizations A full rate review will insure that a hospital's entire financial condition is considered before it is allowed increased revenues

CR52. A fixed dollar threshold for hospital appeals should be set.

Currently the hospital payment system frequently hears appeals which, in dollar terms, are virtually immaterial This contributes to a complex and untimely system To insure that the efforts of all parties are well-spent, a standard of materiality will be set for appeals The sum dollar value of any appeal must exceed that hospital's annual target operating margin be entertained by the Hospital Rate Setting Commission

CR53. Any automatic rate adjustments such as the annual inflation factor and 2 percent prospective adjustment should be eliminated for those hospitals appealing their rates.

Hospitals deciding to pursue a rate appeal will forego those automatic rate adjustments calculated prospectively In a full rate review, a hospital must demonstrate that the automatic adjustments are not sufficient to meet reasonable and necessary expenses The outcome of the rate review will supersede the automatic adjustments

CR54. The backlog in hospital appeals should be addressed before instituting reforms.

Hundreds of millions of dollars in hospital appeals are outstanding These must be settled quickly, otherwise we may be faced with years of future retrospective rate adjustments as these are adjudicated

One way to address the appeal backlog is to have hospitals, the Department of Health, and the Public Advocate negotiate settlements on each hospitals consolidated appeal backlog after review of each hospitals issues by the Department of Health staff Interest costs will not be considered in these settlements Unquantified appeals will not be recognized Settlements will be reviewed by the Hospital Rate Setting Commission

Hospitals failing to reach settlement will have their consolidated appeals adjudicated by an administrative law judge, with review of hospitals' entire cost base, within a fixed time frame Testimony would be given by parties invited to the proceedings ALJ recommendations would then go to the HRSC to consider with any written objections

Rate increases from the adjudicated appeal backlog should not increase any hospitals rates by more than three percent. Should a hospital not be able to recoup the amount owned in one year with this three percent cap in place, then its rate adjustment will continue for greater than one year and until the hospital recoups the total amount

The process of clearing out old appeals would thus be expedited Considering all the appeals at once would allow us to quantify the total effect of their adjudication on the rates HRSC decisions, as always, could be taken on appeal to the appellate division

Balanced Billing

CR55. New Jersey should take legislative action to mandate Medicare assignment to protect senior citizens from the escalating costs of health care.

This legislation should mandate that physicians who treat Medicare beneficiaries, must accept the Medicare approved rate as payment in full

In 1989, New Jersey Seniors paid $129 million out-of-pocket for physician bills In a study compiled by the Health Care Financing Administration in Washington, DC, it was determined that only 25 percent of all New Jersey physicians accepted the Medicare rates as payment in full Seniors on a fixed income often find 20 percent of their income is spent on costs related to health care The average income for seniors in New Jersey is $14,500 which means that an estimated $2,900 is spent on health care costs annually by each of New Jersey's senior citizens

Although Medicare's reimbursement to doctors is based upon "customary and prevailing charges" in each region, only 29 percent of New Jersey doctors will accept these rates as their fees As a result, the average senior is forced to pay up to 60 percent of the doctor's charges whereas he/she should have to pay only the 20 percent copayment as set forth under this program These overcharges are projected to exceed $130 million in 1990 in New Jersey

Based on a Bureau of Labor Statistics 1988 Annual Report, as published in the June 1989 issue of Consumers Union, the Consumer Price Index rose 50 percent from 1980 to 1989 while doctors' charges rose 180 percent. Senior income during this same period did not keep pace with the Consumer Price Index Fifty percent of seniors have no private insurance or employer insurance to cover out-of-pocket costs High out-of-pocket costs lead to delays in seeking medical attention, resulting in emergency room expenses and acute care problems, multiplying costs

The federal government has passed legislation which will require physicians to accept Medicare payment for services delivered to those eligible under Medicare as payment in full by 1996 In January of 1992, the current payment system under Medicare will be replaced by Relative Value Scale, (RVS) This new scale will place an increasing role in determining what physicians are paid until all payments are based on the mandated fee schedule The Governor's Commission on Health Care Costs believe that New Jersey's senior citizens can not afford to wait until 1996

Health Professions

CR56. A program of medical school loan forgiveness should be instituted to encourage primary care physicians to practice in medically underserved areas of the state.

Physicians could be attracted to areas of health manpower shortage through a program of loan forgiveness The federal government, realizing the potential for such programs to enhance access, plans to revive the National Health Service Corps as part of the Minority Health Initiative New York State, through its Board of Regents, maintains its own separate program to encourage physician practice in these areas With or without federal cooperation, New Jersey may be able to create its own innovative program in this area.

CR57. The current structure of medical education in New Jersey should be examined to determine if it is best serving the state's needs.

The task force believes that the concept of the "university without walls" embodied in the University of Medicine and Dentistry of New Jersey deserves further examination The current system of undergraduate and graduate medical education has been in place for approximately fifteen years We need to review it, to insure that it serves the needs of New Jersey

CR58. Clinical Outcomes and Cost-Effectiveness education should be in undergraduate and graduate medical curricula.

Physicians-in-training are not generally taught how to use the results of Clinical Outcomes research in order to practice in a cost-effective manner Some portion of the medical school curriculum should be devoted to these issues, allowing practitioners to develop the habit of carefully evaluating competing modes of diagnosis and therapy, in order to delivery effective and not wasteful health care This education should continue past medical school into residency and fellowship

CR59. Physicians Assistants should be considered for licensure in New Jersey.

Forty-nine states currently license Physician Assistants Only New Jersey does not, though it is home to one of the nation's finest Physician Assistant training programs Physician Assistants have the potential to increase access to needed services in medically underserved areas

CR60. Efforts to address the nursing shortage should be continued.

The nursing shortage continues One effect has been to force hospitals to turn to expensive contract labor to fill nursing needs Positive steps have been taken to alleviate this problem One unique innovative approach, the Nursing Incentive Reimbursement Award Program, has supported creative strategies to enhance the work environment for nurses in New Jersey This project includes a detailed cost-benefit evaluation component New Jersey should continue to seek new ways to confront the nursing shortage

HEALTH DELIVERY SYSTEMS REFORM

The Commission recognized as the central problem in Health Systems Delivery Reform the need for wider, directed delivery of primary care services to promote a "health care" system rather than a "sick care" system Related issues considered included the lack of managed care options and the underutilization of community-based services

CR61. Consideration should be given for a critical evaluation of the State-mandated health and physical education curriculum by a panel of pediatricians, adolescent medicine specialists, mental health professionals, and physical education and other professionals to determine its effectiveness in terms of today's environment and needs.

Greater health promotion should be built into the health education and physical education curriculum with greater chance for real changes in healthy behavior, especially in underserved urban and rural areas

Other Health Delivery Recommendations

CR62. Legislation should be enacted which would change the format used for prescriptions to encourage the use of generic drugs.

Consumers pay between 55 percent and 234 percent more when purchasing brand name drugs instead of generics Legislation has been introduced which would adopt a one-line prescription form for all prescriptions written in New Jersey The one line form would allow generic drugs to be utilized, unless the physician specifically writes "brand medically necessary " The legislation still allows the physician the ability to prescribe brand name drugs, but the physician would have to indicate that on the prescription form

This would bring substantial savings to individual citizens, as well as savings to the Medicaid and PAAD programs These programs represent 25 percent of all prescriptions issued in New Jersey Currently under the federal guidelines, Medicaid receives funding for prescriptions at the cost of the generic equivalent, unless "brand medically necessary" is written on the prescription In 1991, the Medicare program will begin the same procedures for those prescriptions covered by Medicare In attempting to find ways to control health care costs and specifically costs borne by citizens and insurers, this represents yet another step at reducing costs

CR63. The Commission believes that there should be legislation enacted which prohibits physicians from dispensing prescriptions for profit except in limited circumstances.

It is not unusual for physicians to provide their patients with initial doses of medication until the patient can have their prescription filled by a licensed pharmacist However, some physicians are now selling prescription drugs directly to their patients from their offices

Pending legislation would address this issue The legislation would prohibit physicians from dispensing any drugs for a profit for longer then a five-day period This provides the opportunity for physicians who receive samples of drugs to continue to give those without costs to their patients, as well as to address the emergency cases that may arise that require the physician to dispense the drug because the patient is unable to obtain the drug from the pharmacist for whatever reason The Commission supports this concept and believes this will protect consumers

CR64. The Commission recommends that the Legislature reexamine the possibility of allowing the provision of discounts on prescription drugs.

New Jersey is the only State in the Nation where current law prohibits pharmacists from discounting prescription drugs Since such discounting has the potential to save consumers significant out-of-pocket costs, this prohibition should be reexamined

CR65. Legislative and educational initiatives should be pursued to encourage people to develop living wills.

Living wills establish ones wishes with regard to the use of extraordinary mechanical and medical interventions Since an extraordinary amount of health care dollars are expended in the last year of life, such measures as living wills will not only address quality of life issues, but also health care costs

High insurance rates are caused in part by the costs to the health care system of treating those who are uninsured These costs are passed along to the insured either through higher medical costs, as health care providers shift uninsured costs to those who can pay, or through increased social costs as government programs such as Medicaid and Medicare pay for some of the cost Increasing insurance premiums cause more individuals and businesses to drop coverage, leading to more cost shifting to those who are insured More cost shifting leads to higher premiums, furthering a cycle of limitation of health care access and of concentration of the burden for payment on a shrinking group of individuals and businesses The Commission approached this problem with two goals in mind to increase access to health insurance and to contain the cost of health insurance

SUMMARY OF RECOMMENDATIONS

Subsidized Programs to Improve Access to Insurance

The Commission set a goal that every person in New Jersey should have access to basic health care services including their own primary care physician, preventive services, acute care, ancillary services and managed care This goal is best met through the introduction of a comprehensive program of universal coverage, preferably instituted on the federal level Failing the institution of a universal health care model, the goal must be pursued by expanding the rate of insurance coverage through a combination of subsidies and inducements

The Commission determined that the goals of improved access and cost containment are best met in the near future by working within the current system of employment-based insurance The reforms recommended below combine several strategies calculated to serve the above goals while preserving the State economy from unnecessary disruption

In New Jersey, approximately two-thirds of the uninsured are employed or dependents of the employed The employed uninsured are disproportionately concentrated in small businesses Coverage of this group of uninsured can be increased first, by strongly encouraging the use of managed care programs, second, by developing and encouraging low-cost, managed care insurance products, third, by providing subsidies to small businesses choosing to provide insurance to their employers, and fourth, by inducing employers to provide insurance through the creation of penalties

This program of employment-based insurance expansion is coupled with similar efforts to make insurance more affordable for individuals, and with expansion of Medicaid In combination, these efforts will reduce the cost of insurance through product modification and subsidy, and by reducing cost shifting as more residents become insured

CR66 Managed care insurance plans should be encouraged over traditional fee-for-service indemnity plans.

The Commission's recommendations serve both to contain costs and increase access It was determined that appropriate and thoughtfully designed managed health care plans can achieve economies while maintaining coverage, a task much more difficult with indemnity benefit plans Managed care plans offer preventive and wellness programs that judiciously spend resources to keep people healthy, with the economic benefit of reducing the cost of future "sick care "

Managed care programs are also able to select participating providers who are determined to be best able to provide high quality care, in a convenient setting, at a reasonable cost There is an abundant supply of physicians in the state A managed care program would have the expertise and perspective to make judgments among the physicians available, and to contract with the most able and competent at favorable costs For example, the programs can identify "centers of excellence" for some specialty procedures, directing patients to those providers who have demonstrated a high degree of competence and reasonable charges for services

Appropriate managed care programs should be encouraged for all insurance plans The Commission recommends that only managed care programs be eligible for the subsidies described below Further, the Commission recommends that all elements of Blue Cross and Blue Shield be required to move toward managed care

CR67. An affordable, appropriate insurance product for the small business market must be developed.

The Commission reviewed many suggestions for producing a "bare bones" or limited benefits product It is clear that some of the restrictions imposed by current law must be changed or reexamined For example, as is described below, mandated benefits should be reviewed, and insurers should be permitted to create products tied to preferred provider organizations At bottom, however, the Commission rejects the proposition that real savings can be achieved by excluding necessary services from insurance contracts

The emphasis in creating an affordable product should be on appropriately applying managed care principles to ensure that primary care and wellness is encouraged, and that unnecessary, inefficient care is discouraged The elements described below constitute the standards that must be met by any product that will be subsidized No small group or individual may draw a subsidy to purchase insurance unless the product complies with these standards

One proposed initiative would be to provide small employers with the opportunity to purchase affordable health coverage for their employees through the Garden State Health Plan (GSHP) The basic strategy would be to build upon the GSHP's existing network of providers and administrative structure to offer uninsured workers and their dependents a basic and affordable health benefit option not currently available to them in the private market

Two enrollment options could be available (1) a basic plan that covers inpatient services, physician services (primary and specialty care), prescription drugs, laboratory and x-ray services, and (2) a

GSHP

APPROXIMATE ANNUAL PREMIUM ESTIMATES FOR NON-MEDICAID ENROLLMENT
GARDEN STATE HEALTH PLAN

SERVICE	PREMIUM COMPONENTS	PREMIUM SUBTOTALS 1987	1988	1989	1990	1991
1. Inpatient Services		$810	$891	$980	$1,078	$1,186
2. Physician Services		$305	$336	$369	$406	$447
Primary Physician, Specialist						
3. Ancillary Services						
Prescription drugs	$224		$246	$271	$298	$328
Lab & X-Ray	$6		$7	$7	$8	$9
Total Ancillary		$230	$253	$278	$306	$337
4. Other Services						
Podiatrist	$3		$3	$4	$4	$4
Optometrist	$3		$3	$4	$4	$4
Optical Appliance	$5		$6	$6	$7	$7
Prosthetics	$3		$3	$4	$4	$4
Medical Supplies	$26		$29	$31	$35	$38
Total Other Services		$40	$44	$49	$54	$57
ESTIMATED TOTAL ANNUAL PREMIUM		$1,385	$1,524	$1,676	$1,844	$2,027
ESTIMATED TOTAL ANNUAL PREMIUM FOR 1,2,3		$1,345	$1,480	$1,627	$1,790	$1,970

Assumptions: Enrollment for full year; utilization pattern similar to Medicaid eligibles, no adverse or favorable selection; premiums for years 1988 - 1991 were inflated by 10% per year; members and providers to abide by GSHP rules, deductibles and co-payments may be imposed but are not included.
All figures are rough draft estimates only

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supplies, in addition to the basic plan A $3 00 co-payment was not included, but could be added to make the buy-in plan more financially attractive to the employer

The estimated premium schedule has been established to fund the projected costs of the plan The attached contains the approximate annual premium estimates for non-Medicaid enrollment in the GSHP

CR68. Voluntary subsidized programs should be initiated to enable more residents to obtain health insurance.

Targeted subsidies should be provided in a manner calculated to increase the rate of insured persons in the State The program should contain the following elements

(a) The subsidy should be available to individuals and to businesses An individual in a work place not offering insurance, or a self-employed individual should have access to a subsidy to make insurance coverage more affordable

(b) The products eligible for the subsidy must meet the standards described above

(c) Any product offered through the subsidy program should have rate designs, underwriting standards, and loss ratios consistent with standards set by the Department of Insurance

(i) Subsidies or tax credits should only be permitted for products that do not use two-tier rating Two tier rating is a practice that assigns too much predictive credibility to a small group's actual experience It is an overly simplistic method of separating "good" and "bad" small group risks This practice partially defeats the pooling principle central to insurance

(ii) Any insurer participating in the program must demonstrate a loss ratio of 80 percent, ensuring that 80 percent of premium dollars go to subscriber benefits, and not to overhead or administrative costs

The participating insurers would become members of a risk stabilization pool to permit the spreading of the cost of high-risk insureds Insurers with a loss ratio below 80 percent will pay the difference between their loss ratio and 80 percent into the pool, to be paid to insurers with loss ratios above 80 percent.

(iii) Participating insurers will be required to demonstrate that their underwriting practices are consistent with standards set by the Department of Insurance This will require that the insurers accept all applicants without regard for medical insurability The subsidy and the risk stabilization pool will permit the equitable spreading of high risks

CR69. Blue Cross and Blue Shield of New Jersey should be split into a large group and a "public purpose" entity. The "public purpose" entity should be a mechanism for applying a portion of the insurance expansion subsidy.

The Commission agreed that Blue Cross should be reorganized into two entities in order to create one entity with a clear sense of mission to act as the provider of insurance to those who are otherwise unable to afford or obtain it

(a) The large group entity

The large group entity would continue to provide services to the current large group customers The Department of Insurance will require that this new entity be adequately capitalized

The large group entity will be required to create and market innovative managed care programs and closed panel programs, in order to provide for cost-effective and appropriate insurance products for large employers It will also be required to participate in the Medicaid program to the extent appropriate

(b) The public purpose entity

The public purpose entity will be controlled by a new board, charged by unambiguous requirements to serve the public interest It will serve small groups and individuals, on both a subsidized and non-subsidized basis As a public purpose entity, it will be in a unique position to provide services, to try new products on a demonstration basis, and to apply subsidy with a minimum of administrative burden The public policy entity will continue to be insurer of last resort It is hoped, however, that the burden of acting as the insurer of last resort will be shared by other insurers participating in the subsidy program

As is described above, all insurers participating in the subsidy program will be required to meet certain standards for product design, and accessibility Should other insurers enter the subsidized market in compliance with these requirements, the insurer of last resort burden will be shared The public purpose entity will serve, however, even in the absence of competitors in this market, as the statutory insurer of last resort.

CR70. The public policy entity of Blue Cross should be required to community rate its policies unless subsidies sufficient to guarantee affordability are provided.

The Commission struggled with the question of whether the public policy business should be demographically rated (e g , by age, sex and geographic located), or community rated (i e , rated equally for all insureds purchasing the same product)

On the one hand, there was concern that demographic rating was fundamentally unfair, and contrary to the goals of the Commission in that it set the highest premiums for those most likely to need medical care On the other hand, there was concern that the use of community rating might induce those in the lowest risk groups to seek insurance elsewhere, thereby increasing the risk level of the remaining community pool

In the absence of a massive subsidy, demographic rating will lead many of those most in need of care to be priced out of the market. This concern would be greatly reduced if a large subsidy were available, permitting the actual premium paid to be based on ability to pay and not demographic characteristic However, the limited subsidy thought to be available compels the choice of community rating

In order to protect the community rated pool from the loss of good risks, the Legislature should require that all similar policies written on individuals and small groups be community rated

CR71. Funding for the insurance expansion subsidy should be obtained through the broad-based employer assessment and the penalties levied on

employers not providing employee insurance.

The subsidy required to make the insurance products described above affordable to individuals and small businesses will be generated through a health care fund described later in this Report This fund will be raised through broad-based assessments of employers, and through penalties assessed against employers who fail to sue the available subsidies to provide coverage to their employees

The subsidy will be applied both to direct premium reduction for qualifying products, and, where necessary, for funding of the risk stabilization pool described above

CR72. Legislation should be enacted to require that all public contracts awarded by any public entity in New Jersey contain a requirement that the successful bidder demonstrates that all workers employed pursuant to the public contract will be covered by health insurance.

Many employers who successfully bid on public contracts do not provide health insurance for their employees New Jersey law now requires that contracts for certain categories of public works contain a requirement that workers employed under public work contracts receive a "prevailing wage " As a means of expanding health insurance coverage for workers over which the State has direct control, similar legislation should be enacted to require that all public contracts awarded by any public entity in New Jersey contain a requirement that the successful bidder demonstrate, at the time the contract is executed, that all workers employed pursuant to the public contract will be covered by health insurance meeting appropriate standards of adequacy Prior to the enactment of this legislation, its possible effects on small business and minority set aside programs should be carefully weighed

Cost Containment

Existing statutes, regulations and practices can be modified, at little or no cost, to expand the availability of insurance products and to contain the rise in insurance costs

CR73. Unnecessary legal barriers to sensible, cost-effective insurance products should be eliminated.

(a) Indemnity insurance companies should be permitted to issue contracts with service benefits, thereby making generally available in New Jersey Preferred Provider Organizations ("PPOs") PPOs have had some success in containing costs through restricting the panel of health care providers and managing the care provided

(b) The law should be modified to permit life insurance policies to contain health benefits in some circumstances

(c) A program of long-term care insurance should be considered whereby every dollar of insurance coverage purchased would protect one dollar of the insured's assets during the spend-down process for Medicaid coverage

CR74. Loss ratios and rating practices should be subject to strict oversight by the Department of Insurance.

(a) The Commissioner of Insurance should be permitted to enforce a minimum loss ratio of 80 percent, requiring that at least 80 percent of the premiums paid be applied to benefits A risk stabilization pool should be utilized, as described in the section above on the subsidized products

(b) The rating practices of group insurers should be subject to oversight by the Department of Health to protect consumers from unnecessarily restrictive practices

CR75. Premium taxes on insurance premiums should be eliminated.

Taxes on health insurance premiums should be eliminated in order to allow insurers to offer the products at a lower price The savings to insurers should be required to be passed through in premium reductions

CR76. Mandated benefits should be reexamined.

The Commission heard extensive testimony asserting that the cost of mandated benefits unnecessarily increases the cost of health insurance Although the cost was not exactly quantified, it was estimated to be approximately 10-15 percent of premium costs

A State commission should be created, dedicated exclusively to reconsidering the necessity of mandating each of the services now required under State law That commission should determine whether some mandated services should be deleted from the law It should also consider whether some alternative method of ensuring the provision of those mandated benefits can be created

Consumer Protection

CR77. Consumers should be protected from the possible financial failure of insurance companies.

(a) The Commissioner of Insurance should be permitted to establish and enforce standards for adequacy of claim reserves and statutory surplus, according to the nature and severity of risk assumed by insurance companies, service corporations and prepayment organizations

(b) A life and health insurance guaranty fund should be created to protect insureds from loss on the insolvency of insurance companies, service corporations and prepayment organizations

(c) The Commissioner of Insurance should be permitted to limit the percentage of assets which can be held by an insurance company in below-grade investments, e g , junk bonds

CR78. Consumers should be protected from practices excluding them from coverage due to preexisting illness or changes in employment status.

(a) Legislation should be enacted giving individuals who lose their health coverage due to, e g , loss of employment, to continue that coverage at their own expense at a reasonable cost

(b) Legislation should be enacted to require all group contracts for health care benefits of indemnity insurers, service corporations, and prepayment organizations to cover the medical expenses of insureds whose coverage terminates for any reason, when the expenses result from disabilities first incurred while the insurance was in effect

(c) Legislation should be enacted restricting the length of time during which an insurer may exclude coverage for a preexisting illness

CR79. Insurance providers' practice should be reviewed by the Commissioner of Insurance.

(a) Legislation should be enacted permitting the Commissioner of Insurance to regulate the activities of prepayment health plans (HMOs), and the practice of issuing prepayment plans for single services

(b) The Commissioner of Insurance should be permitted to regulate group contracts that are issued out of state for coverage of New Jersey residents

(c) Insurers should be required by statute or regulation to pay the undisputed portion of hospital bills within 30 days Payments made after that time should accrue interest

(d) The Commissioner of Insurance shall establish within the next three months a study group of various interested parties to make recommendations to correct, reduce and remove fraud in health insurance The recommendations should be issued six months from the establishment of the study group

Medical Malpractice Reform

The cost of medical malpractice insurance has caused health care providers substantial concern Although the cost has increased over the last two decades, the more recent trend is toward decreasing premiums and frequency of claims The cost of malpractice premiums continues to be substantial, more significant in the discussion of health care costs is the practice of physicians practicing "defensive medicine" to avoid malpractice claims, thereby needlessly inflating the cost of health care

The final resolution of the problems created by the medical malpractice system is beyond the scope of this Commission Intermediate actions are possible to address the problems of the costs of defensive medicine, and the dangers presented by the few, unqualified and dangerous physicians in practice

CR80. Steps should be taken to moderate the effects of defensive medicine.

(a) A system of clinical protocols should be developed to provide a benchmark of appropriateness for practitioners and reviewing courts A physician who follows the protocols would be entitled to a rebuttable presumption that he or she had exercised appropriate medical judgment in diagnosis The State of Maine and the federal government are developing such protocols, which should be studied for possible adoption in New Jersey

(b) Legislation should require the mandatory offer of a structured settlement of malpractice verdicts valued at greater than $250,000

(c) The state should indemnify physicians for malpractice awards resulting from services given in a voluntary, unpaid setting

CR81. Greater efforts should be made to improve the quality of practice and to remove incompetent physicians from practice.

Several recent studies have confirmed that a few physicians are responsible for a high percentage of malpractice claims

(a) The Professional medical Conduct Reform Act of 1989 (P L 1989, c 300) sets out a comprehensive procedure for monitoring the competency of physicians, and for analyzing malpractice claims experience The Act creates a Medical Practitioner Review Panel to consider information required to be provided by health care facilities, insurers or other sources that tend to call into question the competence of a physician

The Medical Practitioners Review Panel, the State Board of Medical Examiners, and the Department of Health should jointly report to the Governor within one year of the first meeting of the Panel That report should describe the effect of the Act, the activities of the Panel, and any recommendations for further actions necessary to monitor the conduct of physicians

(b) The $10,000 limitations on hospital liability should be reviewed to determine whether their repeal would provide a meaningful incentive for hospitals to oversee more zealously physicians practices

CR82. The problems presented by the malpractice system should be further studied.

(a) A study group charged with a comprehensive review of the malpractice system should develop a set of recommendations to modify existing laws

(b) Any future study group should carefully consider such alternatives to the existing negligence system as no-fault insurance and compensation programs

UNCOMPENSATED CARE REFORM

The Governor's Commission on Health Care Costs believes that New Jersey has four options with regard to addressing the issue of funding care for the close to 1 million uninsured, the majority of whom are working persons, and 25 percent of whom are children

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

(2) Mandate insurance coverage by all employers, and, thereby eliminate the need for the 19

percent hospital tax or a broad-based financing mechanism

(3) Continue the current 19 percent hospital bill tax

(4) Eliminate the 19 percent hospital bill tax and establish a new broad-based financing mechanism coupled with a series of reforms to contain the growth of health care costs, develop lower-cost insurance vehicles, subsidize insurance premiums for employees in the small business sector and for individual purchasers, provide a system of incentives to encourage the purchase of insurance coverage, and a safety net for the residual uninsured

SUMMARY OF RECOMMENDATIONS

After extensive research and deliberations, the Commission makes the following recommendations

CR83. Eliminate the 19 percent hospital bill tax.

CR84. Expand Medicaid to the allowable federal limits to bring in federal-matching dollars for the care of pregnant women and children up to age 6.

CR85. Enroll all eligible Medicaid patients in a managed care system in order to provide better primary and preventive care and reduce Medicaid costs.

CR86. Develop managed care insurance vehicles for the small business and individual markets that offer coverage at roughly half of the cost of currently available products.

CR87. Adopt insurance reforms that allow community rating and eliminate or severely restrict the pre-existing condition exclusions.

CR88. Adopt a broad-based funding mechanism equal to 1 percent of the first $14,400 of employee wages ($144), to be paid by all employers. This would yield an estimated $451.7 million. (2% would yield approximately $903 million).

CR89. Provide a subsidy to assist in the purchase of insurance for persons between 100 percent and 300 percent of the federal poverty level. Subsidy would be provided for approved managed care plans only.

CR90. Employers who do not take advantage of the above reforms, (coupled with the current incentive of the tax deductibility of health insurance premiums), for the purpose of providing health insurance coverage for their employees and their dependents, and who can not evidence that these employees are covered through another plan, will be assessed a penalty of $1,000 per full-time employee and $750 per part-time employee. This penalty is to help defray the costs to all New Jerseyans for the medical costs of their uninsured employees and should be set at a level so as to be significant to provide a clear financial incentive to purchase insurance.

The Commission considered the financial impact to New Jersey's businesses as a result of this plan

For the employers who currently provide health insurance to their employees, most of whom share in these costs through deductibles and co-payments, it means an elimination of the 19 percent hospital bill tax that they pay through their health insurance premiums This would substantially reduce their premium costs

They would pick up the costs of approximately $144 per employee to fund a New Jersey Health Care Fund to be allocated for the purposes identified later in this report

They would not pay the penalty

For example, Company X has 1,000 employees and health insurance costs of $4 million per annum (averaging $4,000 per employee)

If approximately 55 percent of the costs of their health insurance is attributable to acute care costs, that equals $2 2 million per year An average of 19 percent of that cost is the hospital tax for the Uncompensated Care Trust Fund Therefore, Company X is currently taxed $350,000 per year to support the uninsured and bad debt costs of other New Jersey citizens ($1,850,000 Actual Costs + 19 percent Tax = $2 2 million)

If the 19 percent tax is eliminated, as recommended by the Commission, then Company X's insurance premium will drop from $4 million dollars per year to $3,650,000 per year (Many large employers are self-insured for dollar-for-dollar costs and utilize insurance companies for the purpose of administering their health benefits plans)

Under the Commission's Plan, Company X would begin to pay $144 per employee into the New Jersey Health Care Fund, a total of $144,000

Company X would not pay any penalty because it provides a health insurance plan for its employees

In sum, under the Commission's recommended plan, Company X would realize a net savings of $206,000 per year on its health insurance costs

This savings is now free for other costs of doing business, such as employee wages, other benefits, research and development, or to allow the company to price its product more competitively

Let's look at one actual New Jersey company

Allied Signal has 5,400 employees in New Jersey Last year, it spent $1 2 million dollars for the hospital bill tax for the uncompensated Care Trust Fund

Under the Commission's Plan, Allied Signal would no longer pay this $1 2 million, but would pay in its place a $144 per employee for a total of $777,600 The savings to Allied Signal, its customers, and its employees who may be sharing higher deductibles and co-payments, would be $422,400 per year

Now let's examine the experience of the small employer

Company Y is a small accounting form employing 10 people They do not have a company health insurance plan because the costs of obtaining such a plan are prohibitive Currently, because this small company would be experience-rated, and one of its employees is diabetic, and one has a history of heart disease, its insurance premium would be exorbitant. Moreover, all of its employees would not be covered or only covered on a limited basis due to the exclusion of coverage for any pre-existing condition Company Y's 10 employees are left to obtain health care only when their situation becomes so acute as to leave no other choice, thereby eliminating or severely limiting preventive and primary care When medical attention is unavoidable, this care is usually sought in a hospital emergency room at the high cost of an acute care visit, rather than in a physician's office or community health facility, because cash is not required for care

The Commission's plan offers several reforms to the insurance market to make health insurance more affordable to this small accounting firm These include the provision of a low-cost, managed care insurance policy for individuals and small businesses, community rating, a limitation on pre-existing conditions exclusion, and other recommendations The Plan proposes a subsidy and Medicaid buy-in for the employees of the firm who earn under 300 percent of the poverty level ($38,100 for a family of four)

The new low-cost managed care product is expected to average less than $2,500 per employee (less for single persons, slightly more for family coverage) With federal and state tax savings for health insurance costs, the cost would be reduced to approximately $1,640 per employee With a limited subsidy available for the employees of small businesses, the costs would be further reduced An employee contribution would reduce the next cost yet further

The employer may choose to continue to let his employees go uninsured, and pay a penalty of $1,000 per employee in addition to the $144 state-wide contribution per employee Or he/she could take advantage of the reforms and incentives and obtain health insurance coverage

The Commission believes that the vast majority of employers are responsible employers who would purchase health care coverage if it were affordable The Commission notes, however, that after a reasonable period of time, if such does not prove to be the case, then the penalties should be increased so as to strengthen the financial incentive to purchase insurance

The Governor's Commission on Health Care Costs has reviewed the current operation of the Uncompensated Care Trust Fund (UCTF) Items that were thoroughly examined were, how UCTF is funded, who is eligible, general descriptions of the participants, what types of services are utilized, and how to best guarantee access to health care for the uninsured

The uncompensated care fund was created by the Legislature to establish a collection and distribution system to pay hospitals who provide services to the uninsured This system guarantees unlimited access to hospital based care Prior to this legislation, urban hospitals bore a disproportionate share of the cost of care for the uninsured which placed them at a competitive disadvantage for paying patients

The fund currently pays for hospital services of those who qualify for charity care and those who do not pay their bills To qualify for charity care, there is a sliding scale formula that will cover anywhere from 20% to 100% of the hospital bill depending on the patient's annual income and liquid assets For those individuals who are deemed able to pay but don't, there are required collection procedures Failure to pay may result in liens on any property or assets which the individual may have

The UCTF is currently funded through a hospital-based tax on all inpatient hospital bills In FY '89 the average hospital tax was 19 percent Medicare no longer contributes as a payer to the UCTF and costs previously borne by Medicare are shifted to other payers

Uncompensated care costs have increased an average of 17 percent per year Since 1983, uncompensated care costs have increased from $288 million, to $500 million in 1988 This year the fund is expected to exceed $700 million Blue Cross and Blue Shield of New Jersey estimates that in 1990, $ 30 of every $1 00 of hospital premium they collect will go to cover uncompensated care costs and the costs of the Medicare cost shift.

From data collected by the Current Population Survey, we are able to examine selected characteristics of the State's uninsured population Demographic characteristics of specific interest are family income, employment status and age (Source Analysis by Urban Institute, 1986)

* There is a strong association between low income and lack of insurance About 25 percent of New Jerseyans with a family income below the federal poverty level lack health coverage Looked at another way, roughly 2/3 of the State's uninsured population has a family income below 300 percent of the federal poverty level As a point of reference, the 1990 federal poverty level of an individual is $6,380, three times this level is $18,840 Income of the uninsured is of special relevance when it is examined in conjunction with the average cost to purchase health coverage, which some estimate at $3,000 in New Jersey

* A strikingly large portion of the uninsured are working New Jerseyans Roughly 40 percent of uninsured New Jerseyans fall into the category of employed adult. When dependents of employed persons are included, the portion of uninsured New Jerseyans linked to the work force -- either on a part-time or full-time basis -- exceeds two-thirds

* The uninsured tend to be young More then 50 percent of the uninsured population in New Jersey are younger than 25, children younger than 18 years account for more than 25 percent of the State's total number of uninsured

Uninsured Admissions to Hospitals

* Maternity-related hospitalizations represent roughly 20 percent of uninsured inpatient dollars and 35 percent of all uninsured admissions (Source Department analysis of 1986 hospital bills)

* Hospitals are required, beginning in 1990, to ask patients (insured and uninsured) if they are employed or not employed Data on employment status has not yet been aggregated and analyzed, in early 1991 and 1990 data on employment status will be available for examination This information is only being asked of persons admitted to a hospital, there is no uniform reporting for outpatient care

Persons Whose Bills Contribute to Uncompensated Care

In contrast to demographic data available on the State's uninsured population, information to describe actual users of uncompensated care is limited, thus the Department of Health has frequently relied on data on the State's uninsured population as a rough proxy What we do know about uncompensated care is summarized below

* At least 20 percent of uncompensated care dollars is reported as charity care and thus, by definition, is generated by persons with incomes below 250 percent of the Federal poverty level e (Source Chapter 83 Actual Forms, 1989) This percentage is widely thought to seriously understate the portion of uncompensated care which is charity care for three reasons

  1 Regulations only permit the designation of charity care if documentation of eligible income and asset levels is provided by the patient, the population eligible for charity care may not always be able or willing to provide documentation If documentation is not provided, the patient bill -- presuming it is not paid -- falls in the bad debt category

  2 A review of the ratios of charity care to uncompensated care across individual hospitals provides additional information Most dramatically, in 1989 two large inner city hospitals each reported less than 1 percent of their uncompensated care as charity care In contrast, two suburban hospitals in wealthy communities reported charity care amounts which represented 62 percent and 44 percent of their total uncompensated care These findings underscore the extent to which charity care is under-reported, particularly in inner city hospitals -- hospitals which represent the bulk of the State's uncompensated care amount

  3 We know from the Current Population Survey that about 66 percent of New Jersey's uninsured population has a family income less than 300 percent of the poverty level One would expect a statewide ratio of charity care to uncompensated care similar to 66 percent -- instead of the reported 20 percent.

* Roughly 70 percent of uncompensated care dollars is generated on the inpatient side and 30 percent in outpatient departments Outpatient departments are defined by the hospital rate setting system to include eight settings emergency rooms, clinics, same day surgery, off-site health services, private referred, same day psych, outpatient surgery, and mobile intensive care units (Source Chapter 83 Actual Forms, 1989)

* Beginning in 1990, hospitals are required to ask patients without health coverage and patients with less than comprehensive coverage questions about their income level Income information will be found only in the patient file (i e , not on the hospital bill) and thus would require a survey of patient files prior to any analysis As this is a new requirement, it has yet to be aggregated and analyzed To the extent this information is correctly given by patients, more will be known about the income levels of users of uncompensated care from 1990 forward

Factors Influencing Amount of State's Uncompensated Care

The following reasons are given by different parties to account for the increases in uncompensated care

A Overall hospital inflation in New Jersey, resulting from annual economic factor increases, rebating and the shifting of the Medicare shortfall (portion not related to uncompensated care) to non-Medicare payers Hospital inflation affects the size of all bills, including uncompensated care bills

B Increase in the number of uninsured (self-pay) admissions to hospitals Between 1985 and 1988, uninsured admissions increased statewide by 20 percent Increase in number of uninsured outpatient visits

C Increase in severity of the medical conditions of uninsured patients admitted to hospitals, e g , persons with HIV diseases and newborns addicted to drugs, result in larger unpaid hospital bills

D Increase in private insurers' use and magnitude of cost sharing requirements Increased cost sharing leads to an increase in unpaid deductibles and co-payments, i e , increase n bad dt associated with insured persons

E Factors that influence a hospital's ability to collect unpaid accounts, such as a change in the State's economy, impact the size of bad debts

F Individual hospital accounting practices also result in annual fluctuations -- both increases and decreases -- in reporting hospital bad debt

It is difficult to say what portion of the aggregate increase in uncompensated care -- as well as hospital-specific increases and decreases -- can be attributed to each of the above factors We do know, however, that a significant portion of the recent increase in uncompensated care is attributable to the increase in overall hospital inflation in the State, i e , "A" above The Commission's recommendations to reform and contain hospital costs, contained in another section of this Report, will impact uncompensated care costs

The Commission embraces that philosophy that everyone should have access to health care services and that it is a societal responsibility to finance such care Given the high cost of medical care, steps must be taken to contain the cost of uncompensated care This only can be accomplished by decreasing our reliance on the Uncompensated Care Trust Fund and increasing the number of people with insurance

The Commission believes that as important as the issue of the method of raising the revenue to support uncompensated health care is how these dollars are spent.

In 1989, it was estimated that the Uncompensated Care Trust Fund (UCTF) would be $514 million The mark-up factor was predicated on this number Estimates of the UCTF are derived from examining the previous year's costs and escalating them forward by an inflationary factor Actually costs are then viewed prospectively in order to estimate the following year's costs

Actual costs for the UCTF in 1989 exceeded the estimate by up to $239 million (unaudited), totaling over $750 million The 1990 amount is expected to approach $800 million If the fund were to continue to grow in excess of 17 percent per year, New Jersey can expect the following levels of uncompensated care in the ensuing years

YEAR	AMOUNT OF UNCOMPENSATED CARE
1991	$ 815 MILLION
1992	$ 958 MILLION
1993	$1.121 BILLION

The surcharge, as the current taxing method to raise this revenue, would increase as well

The UCTF reimburses hospitals for the costs of charity care and bad debt The UCTF assures universal access to hospital care, and ensures the solvency of New Jersey's hospitals, but it has several weaknesses

1 The UCTF is supported by a tax on hospital bills which in turn drives up the cost of health insurance By taxing those who purchase health insurance to pay for those who either can not or choose not to purchase health insurance, it represents an unfair tax burden on certain New Jersey citizens and businesses

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

3 The current UCTF tax drives up the cost of health care causing more citizens and employers to be unable to afford health insurance, thereby increasing the ranks of the uninsured. More uninsured, more costs to the UCTF, more tax on hospital bills

4 The current UCTF pays for health care at its most expensive store - the acute care hospital It does not compensate for care that could be provided in community health care centers, or by expanding and encouraging a primary care network An uninsured person cannot visit a physician in a low-cost community health setting for a non-acute illness, such as a minor respiratory infection, without means of payment, but can go to the hospital emergency room at a cost of perhaps three to four times the cost Such financial incentives are counter to controlling health care costs They are likewise counter to the tenets of preventive and primary health care Uninsured persons are likely to delay a medical visit until an uncomplicated respiratory infection progresses into more complicated illness such as bronchitis or pneumonia, perhaps necessitating a hospital stay What, therefore, could have been a $30 visit, has the potential to turn into a hospital stay costing several thousands of dollars - with the bill being picked up by the same UCTF that is not allowed to pay for the $30 visit

5 The primary method by which the costs of uncompensated care can be reduced is by increasing the availability and affordability of health care insurance However, the current uCTF does the opposite on both accounts The UCTF does nothing to expand the availability of insurance for low and middle income working people The UCTF makes insurance more and more unaffordable with each increase in the tax on hospital bills

The section of the report concerning insurance reform addresses some of these issues

In 1985, Robert Wood Johnson Foundation invested $6 2 million to fund demonstration projects across the country to break down barriers between insurers and small businesses The projects have had limited and mixed results Their research has identified the following factors which characterize the small business market

(1) Marketing plans to small businesses can be expensive because small firms are not easily identifiable They are usually new businesses, with a high likelihood that they will fail in the first two years Often they do not understand insurance and offer few, if any, benefits to their employees

(2) The small business market is usually not any riskier than larger employers according to Robert Wood Johnson's preliminary data Each project, now operational in 10 different states (AZ, MI, ME, WA, WI, TN, FL, CO, UT, CA), have common goals managing care, controlling costs, and providing state and/or private subsidiaries for marketing

(3) Some projects subsidize out-of-pocket expenses for low-income workers In Maine, the legislative provides direct subsidies to low-income workers In Colorado, low-income workers are seen in the public hospitals through an Exclusive Provider Network (EPN) Low income workers who are unable to meet deductibles and co-payments are covered fully thought eh public hospitals' indigent care funds

(4) Seventy-five percent of the 31-37 million uninsured Americans are employees or dependents of employees

(5) Nearly one half of the salaried uninsured work for businesses with 10 or fewer employees

(6) The high cost of health insurance is identified by small businesses as the number one reason why they lack insurance coverage Other primary reasons include the ability to recruit and retain employees without providing insurance coverage, medical underwriting practices that disqualify firms by size, workers pre-existing conditions, or type of business

(7) Insurers identify high marketing and administrative costs and the fear of excessive losses as the major reasons they do not enthusiastically pursue the small business market

Robert Wood Johnson researchers have concluded that a combination of cost containment (through managed care and other mechanisms) and reinsurance to limit exposure to catastrophic losses, can control costs and spread the risks for insuring the small business market Any successful initiative would have to address the major barriers of limited funds for purchasing insurance, employer and employee sensitivity, and high employee turnover

CR91. The New Jersey Health Care Fund, replacing the current Uncompensated Care Trust Fund, should target its resources to reduce the reliance on hospital-based uncompensated care.

The many challenges that confront the Governor's Commission on Health Care Costs with regard to the accessibility and costs of health care to New Jersey's citizens, its employers, and its government clearly identified the need to spend the dollars raised for uncompensated care, (irrespective of the method of raising the dollars) in a smarter fashion The Commission identified the following goals for allocating this fund more wisely

(1) GOAL: Expand Insurance Coverage

Subsidizing the purchase and retention of insurance coverage for employees of New Jersey's small businesses Such subsidization should be limited to employees within 300% of the federal poverty level, and their dependents, and would cover co-pays and deductibles for part of this population, (Additional discussion of the insurance coverage and delivery systems are addressed in other sections of the Report)

(2) GOAL: Move From Sick Care to Health Care System

Support for preventive and primary care initiatives that address early identification and treatment of illness in non-hospital settings Specifically, ongoing stable support for community and neighborhood health care delivery programs in existence and for expansion of such programs

(3) GOAL: Targeted and Early Identification and Treatment of HIV Positive Population

A major increase in State funds available for testing and out-of-hospital treatment and services to HIV positive population in New Jersey Programs would address family needs particularly of women and children who are victims of AIDS

(4) GOAL: Provide Support for a Citizen-Driven, Local Health Plan Process

The provision of stable support for a local health planning process to determine, in concert with regional and state level agencies, health care delivery priorities and the rationing of limited health care dollars

(5) GOAL: Expansion of Medicaid to Maximum Allowable by Federal Law

Provide State-matching funds to expand Medicaid to 185 percent of poverty level for targeted population of women and children

(6) GOAL: Early Prevention and Treatment for All New Jersey Children Up to Age 17

Provision of funds for specific prevention and early intervention initiatives, like pediatric vans, to reach urban and rural children at risk

(7) GOAL: Coverage for Uncompensated Care Costs of Residual Uninsured for Acute Care, and for Primary Care in Specific Settings

Even with the above initiatives and other major recommendations in this Report, there will always be those who remain uninsured funds should continue to be provided to cover the acute car and outpatient costs of charity care for these patients

There was unanimous agreement among Commission members and every testifier or presenter to the Commission, including submitted documents, that the current method of financing uncompensated care through the tax on hospital bills was an unfair tax and contributed to making health insurance more unaffordable to more and more New Jersey citizens

Unfortunately, to many in the business community, and to the general public, the current method of raising the revenue for uncompensated care, the tax on hospital bills, passed on as raises in their insurance premiums, is a largely hidden burden Because they often do not see this tax directly, many are unaware of its existence, or the problems it presents

As unanimous as was the agreement that tax on hospital bills was unfair and significantly added to the costs of health insurance, so also was the call for a broader based financing mechanism

In fact, a mid-year survey of New Jersey's business leaders identified the costs of health care insurance as the number one problem affecting New Jersey businesses

Some have suggested to the Commission that revenue be located in the current State budget for this purpose The Commission concluded that while this would be a potentially attractive solution, it is an unrealistic option considering the lack of available revenue within the budget

One suggestion was an elimination of the current tax ranging this year from 17 3% to 19 4% per hospital bill, and replacing it with a flat tax per employed person for $150-$200 annually A levy of $200 to be paid by employers, or with a small cost sharing by the employee, would raise approximately $700 million dollars per annum while significantly reducing the costs of health insurance This broad-based financing mechanism would fairly distribute this societal burden and at the same time make heath insurance more affordable for all businesses and individuals The Unemployment Insurance system could be an efficient and effective method to collect this revenue

The Commission considered the flat tax, a pay or play system, mandating insurance, a value-added medical services tax, and several other approaches

The Commission's conclusion was to recommend an approach which eliminated the 19 percent hospital bill tax and replace it with a 1 percent of the first $14,400 of wages tax coupled with a penalty of $1,000 per uninsured employee

Finally, the Commission was troubled by the lack of available discrete and verifiable data on who the users of uncompensated care were and specific information on its components of cost and reasons for its levels of increase The current data available to the Department of Health, in the view of the Commission, was lacking in several key areas Such gaps in information make a definitive statement to New Jersey's citizens to support a specific new funding mechanism more difficult

CR92. A complete audit of the Uncompensated Care Trust Fund is necessary.

The issue of high levels of uncompensated care has been in the forefront of the Commission's deliberations in part because there is a widespread perception that most of uncompensated care is bad debt, which is perceived to be attributable to "deadbeats" who can, but don't, pay for health care The Commission was informed that 82 percent of uncompensated care is bad debt, while only 18 percent is charity care

This perception is misleading for two reasons First, many people not eligible for charity care are nevertheless medically indigent, and are therefore unable to afford at least a part of large hospital bills Market basket surveys demonstrate that people have no disposable income to pay for health coverage until their income exceeds at least 250 percent of the poverty level Much of the "bad debt," then, is attributable not to deadbeats, but to indigent patients who simply cannot pay

The Department of Health has prepared several recommendations to address the data deficiencies relating to uncompensated care

EPILOGUE

The Governor's Commission on Health Care Costs spent six months examining New Jersey's health care system We only scratched the surface

The issues that confront this Nation with regard to health care policy require major systemic reform To neglect the need for this reform only ensures that the pressures that cause rising costs and declining access will continue This national problem hurts not only the people of this nation directly, and at the time when they are most vulnerable, but also threatens our Nation's competitiveness in the world marketplace

New Jersey is far from a consensus on these issues The roots of the causes of health care cost increases are complex and, sometimes, all but invisible If you have not been sick, you don't know that our health care system is sick If you are not aware of how our system is financed, you don't know that it is flawed Even those who do know these things are not in agreement on how or if it should be fixed -- for to fix it means to address some fundamental financial and economic issues

The Commission presents the result of its deliberations as a starting point for the discussions and decisions that must follow If not now, then later The reform of the system is inevitable, for the economic pressures will make it so

Most importantly, whether the decision-makers choose to continue the current system or to reform it, the Commission believes that a safety net for the uninusred must be maintained To do less would deny care to our children and all citizens of our state when they need it the most

GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

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Commissioner
Department of Insurance

Raymond Bramucci
Commissioner
Department of Labor

Wilfredo Caraballo
Public Advocate

Douglas Berman
Treasurer
Department of the Treasury

DOCUMENTS RECEIVED

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
1A	Labor's Departmental Presentation to the Commission		Commissioner Bramucci
1B	Human Services Departmental Presentation to the Commission		Commissioner Gibbs
1C	Health's Departmental Presentation to the Commission		Commissioner Dunston
1D	Insurance's Departmental Presentation to the Commission		Commissioner Fortunato
1E	Public Advociate's Departmental Presentation to the Commission		Public Advocate Carabella
3A	University Health System of NJ 5/8 Presentation	Thomas Terrill	
3B	Home Health Assembly of NJ 5/8 Presentation	John Paul Marosy	
3C	Citizens Commission on AIDS 5/8 Presentation	Gary Stein	
3D	NJ Head Injury Assoc 5/8 Presentation	Barbara Geiger-Parker	
3E	Fair Oaks Hospital 5/8 Presentation	James Lape	
3F	Candelighters 5/8 Presentation	Eileen Hoey Chairperson	
3G	Cathedral Healthcare Systems 5/8 Presentation	Margaret Straney	
3H	NJ Physical Therapy Assoc and NJ Coalition of Opticians 5/8 Presentation	Russell Bent	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
3I	NJ Public Interest Research Group 5/8 Presentation	Patricia Dorsey	
3J	UMDNJ-Robert Wood Johnson Medical School 5/8 Presentation	Frank A Simon, MD	
3K	New Jersey Carpenters Fund 5/8 Presentation	George Laufenberg	
3L	Franklin Health Group 5/8 Presentation	David Levy, MD	
3M	UMDNJ-University Hospital 5/8 Presentation	Ronald Napiorski	
3N	Legal Services of NJ 5/8 Presentation	Melville Miller, Jr	
3O	Family Planning Assoc of New Jersey 5/8 Presentation	Katharine Pinneo	
3P	UMDNJ-Minority Health 5/8 Presentation	Douglas Morgan	
3Q	Axiom Review 5/8 Presentation	Gilbert Melnick, MD	
3R	American Academy of Pediatrics 5/8 Presentation	Dr. Joseph Bogdan	
3S	Laborer's National Health and Safety Fund 5/8 Presentation	James LaPenta	
3T	Travelers Insurance Co 5/8 Presentation (CT Blue Ribbon Commission State Health Report)	John Troy	

#DOCUMENT TITLE		SOURCE	INTERNAL SOURCE
3U	Candelighters 5/8 Presentation	Deborah Centrella (Parent)	
3V	NJ Association of Nurses Anesthetists 5/8 Presentation	Linda Tisdale	
3W	U S Healthcare 5/8 Presentation	Laurie Hawkins	
3X	Universal Perscription Administrators 5/8 Presentation	Mr Konigsderg	
3Y	New Jersey Primary Care Association, Inc 5/8 Presentation	Debby Hoffman	
3Z	Mary Goldman and Assoc 5/8 Presentation	Mary Goldman	
3AA	New Jersey Citizen Action 5/8 Presentation	Lee Rosenthal	
3AB	Home Health Services and Staffing Assoc 5/8 Presentation	Jean Alan Bestafka	
3AC	National Health Plan Corp 5/8 Presentation	Mr Zabeck	
3AD	NJ State Nurses Assoc 5/8 Presentation	Jane Adams	
4A	NJ Food Council Testimony Testimony to Commission	Barbara McConnell	
4B	Proposal to Decrease Cost of Health Care	John Hancock Life Insurance Walter F Morris	
4C	Comments on Long-Term Care Component	NJ Assoc of Non-Profit Homes for the Aging	
4D	Position Statement on Funding Local Health Planning Agencies	Health Care Planning & Marketing Society of NJ	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5A	Blue Cross/BS Ltr from subscriber & supporting documents re errors	Robert Beck, RaBeck Ind	
5B	A proposal to drecrease the cost of health care in NJ	Thomas J Kean The Thomas J Kean Company	
5C	Summary of Albany Conference on "Universal Health Care" Voices from the State"	Bruce Seigal Peggy McNamara	Bruce Seigal
5D	Connecticut Blue Ribbon Commission on State Health Insurance Report	T Peter Libassi Travelers Ins Co	
5E	American College of Physicians Position Paper on Access to Care	John Middleton, M D New Jersey Chapter	
5F	Ltr from Charles Marciante re 3 major changes	Charles Marciante	
5G	Memo from Bill Foster re State bidding requirement for health coverage		William Foster Chief of Staff, Dept of Labor
5H	Package to Commission members for 5/22 mtg		Denise Brouillard
5I	(A) Universal Access to Health Care In America Moral & Medical Imperative (5/01/90)	Annal of Internal Medicine Editorial	Bruce Seigal
	(B) Access to Health Care	Americal College of Phy Annals of Internal Medicine	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5J	A Call for Radical Surgery & various news articles	Time Magazine & others re American College of Phy	Bruce Seigal
5K	Remarks by Louis W Sullivan, MD 4/26/90 to ACP	Dr Sullivan	Bruce Seigal
5L	Virginia Plan Summary		Bruce Seigal
5M	Access to Health Care Legislative & Organizaitonal Proposals	Washington Bus. Group on Health	Bruce Seigal
5N	Uny*Care· New York Plan	NY State Dept. of Health	Bruce Seigal
5O	Massachusetts Health Plan	State Health Notes	Bruce Seigal
5P	The Pepper Commission Report	Pepper Commission	Bruce Seigal
5Q	For the Health of the Nation Report of the National Leadership Commission on Health Care	Nat Leadership Commission	Bruce Seigal
5R	The Oregon Basic Health Services Act	Oregon Senate	Bruce Seigal
5S	Cost Containment Articles "Facing Up To the Challenge of DRGs"	Dr. Lattimer Health & Social Work	
	"Cost Containment and the Quality of Medical Care. Rationing Strategies in an Era of Contrained Resources"	Milbank Memorial Fund Quarterly	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5S CONTINUED			
	"How the U S Spent Its Health Care Dollar 1929-1980"	Health Affairs	
	"DataWatch"	Health Affairs	
	"Market-Oriented Cost-Containment Strategies and Quality of Care"	Milbank Memorial Fund Quarterly	
	"Social Work in Teaching Hospitals and Expansion of For-Profit Health Corporations"	Health & Social Work	
	"Evaluation of Arizona Health Care Cost Containment System, 1984-85"	Health Care Financing Review	
	"Home Health Services in a Climate of Cost Containment"	Home Health Care Services Quarterly	
	"Has Cost Containment Gone Too Far?"	The Milbank Quarterly	
	"Cost Containment In Health Care"	National Center For Social Policy & Practice	
5T	Medical Indigency and Uncompensated Health Care Costs	Nat'l. Conference of State Leg	Bruce Seigal
5U	Including the Poor	Health Policy Agenda	Bruce Seigal

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5V	Access to Health Insurance in the United States	E Richard Brown	Bruce Seigal
5W	Ohio Insurance Task Force Report	Ohio Dept of Insurance	
5X	Hawaii State Health Insurance Program Smry	Hawaii Dept of Health	
5Y	Hawaii SHIP Legislation	Hawaii Dept of Health	
5Z	Hawaii Prepaid Health Care Act	Hawaii Dept of Labor	
5AA	University Health System of NJ Draft Statement of Position	University Health System	
5AB	Scope of Services to be provided to Commission	Foster Higgins	
5AC	Outlined proposal to maximize Medicare reimbursement	Domenick Camisi NJHA	
5AD	(1) "A Grassroots Movement in Bioethics" (2) "In the Forefront"	Community Health Decisions Publ Health Care Allocations	Dr. Frances Dunston
5AE	Outside interference to practicing physicians	Medical Society of New Jersey	
5AF	Liability expenses adding to high cost of health care	Carlton J Fullilove, CFP	
5AG	Health Care Financing Authority - 1990 Data Compendium		William Toby Regional Admin

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5AH	Registration of Denturists	Denturist Society of NJ Sidney Schneider	
5AI	Personal side of high cost of health care	Annie Leber Livingston, NJ	
5AJ	Briefing Paper Health Facilities, Financing, and Regulation in NJ With Slide Presentation		Dr Bruce Seigal
5AK	Uncompensated Care Trust Fund Assuring Universal Access to Hospital Care in New Jersey		Dr Bruce Seigal
5AL	Public Health Council's Oral Presentation to Commission	Milton Prystowsky Chairman	
5AM	Statewide Health Coordinating Council's Oral Presentation to Commission	Robert Friedman Vice Chairman	
5AN	Health Care Administration Board's Oral Presentation to Commission	Thomas Foley Chairman	
5AO	Report of the Health Care Facilities Financing Authority	Kay Fern Executive Dir.	
5AP	Clarification and Rationale used in original testimony	Douglas Morgan Minority Health Institute UMDNJ	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
5AQ	"Labor & Management on a Course over Health Care" A Study by Dept of Public Policy Service Employees Int Union	Angelo Genova Genova, Burns & Schott	
5AR	Letter of Personal Health Care Knowledge	Joseph F Bishop	
5AS	Governor's Weekly Bulliten "Governor's Discuss Health Care Issues with Congress"	National Governor's Association	Christina Klotz
5AT	Shared information from the Medical Socity of NJ's most recent meeting in Atlantic City	Joseph Riggs, Pres -Elect	
5AU	"Finding the Levers, Finding the Courage Lessons from Cost Containment in North America"	Robert Evans Univ of British Columbia	Dr Lattimer
5AV	"Problems and Approaches in Health Care Decisionmaking The NJ Experience" A Report of the NJ Comm. on Legal and Ethical Problems in the Delivery of Health Care	Senator Gabriel Ambrosio	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
6A	Personal suggestions re health care issues	Ruth Butts	
6B	(a) Testimony presented to Assembly Health Care Policy Study Commission	David Wagner St Barnabas Med Ctr	
	(b) Hawaii Laws and Regulations		
6C	(a) Former Commissioner Merin's Initiative on Guaranty Fund		Clay Cardinal Dept Insurance
	(b) Corresponding White Paper		
6D	Mandated Benefits Insurance Issues Paper		Clay Cardinal Dept Insurance
6E	Suggestions and comments on health care issues and focus points	Louis Keeler Keeler, McNamara Urology Assoc	
6F	Constituent Form Letter High cost of health care	Nina Iwaszczenko	
6G	Constitutent Form Letter High cost of health care	Jerome Oehlman	
6H	Constituent Form Letter High cost of health care	Maxine Sarim	
6I	Hillsdale Board of Ed Resolution for increases in the NJ Health Benefits Program	Elizabeth Randall Assembly	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
6J	New Jersey Citizen Action Organization's Plan for Commission to develop a "Universal Comprehensive Health Care System" with attachments	Thomas Foy Assembly	
6K	Suggestions on BC/BS policy revamping requirements	Ginger McRae	
6L	Medicare grouping and reimbursement adjustments (especially affecting Newark Mini Surgi Site)	Raymond Brown Brown, Brown & Kologi	
6M	Advisory Graduate Medical Education Council's introduction and offer of assistance	Stan Bergen UMDNJ	
7A	Notification of forthcoming information on malpractice suits and high insurance premiums	Milton Prystowsky Public Health Council	Charles Marciante
7B	Suggesting inclusion of <u>all</u> health services within one Department (i e , Div of Medicaid and Div of Mental Health and Hospital under the Dept. of Health	Ernest May, Ph D Board of Trustees Christ Hospital	
7C	Input on health care crisis and possible solutions	Bernard Rabinowitz	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
7D	Background information on the regulatory boards and councils of the NJ Dept of Health		Joseph Kale Dept of Health
8A	Blue Cross/Blue Shield recommendations to the Commission (6/12 Testimony)	Donald Daniels Dr Petillo	
8B	Statement of the Medical Society of NJ (6/12 Testimony)	Louis Keeler, M.D Trustee	
8C	Testimony and recommendation from NJ Hospital Assoc. (6/12 Testimony)	Louis Scibetta President	
8D	Testimony of the Health Insurance Assoc of America (6/12 Testimony)	Woodrow Eno Assoc General Counsel	
8E	Testimony of Hospital Rate Setting Commission	William Cornetta Chairman	
8F	Presentation by NJ HMO Association	Sharon Hayman President	
8G	Presentation Paper from Garden State Health Plan		Thomas Russo
8H	Hospital Panel St Barnabaus Med Ctr's Presentation	Ronald DelMauro President	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
8I	Hospital Panel South Jersey Health Systems Presentation	Paul Cooper President	
8J	Hospital Panel Muhlenberg Regional Med Ctr Presentation	David Ridgway President	
8K	Hospital Panel. Cathedral Healthcare Systems Presentation	Margaret Straney President	
8L	Proposal for Improving U.S Health Care System by the Medical Society of the State of New York	Stan Bergen UMDNJ	
8M	Copy of letter to DOH expressing concern over the increase in the Medicare Cost Shift calculations	Don Daniels Blue Cross/ Blue Shield	
8N	Controlling Health Care Costs by addressing over-utilization of services	Robert Maurer Medical Inter-Insurance of NJ	
8O	"The Sickening Spiral" Health Care Costs Continue To Grow At An Alarming Rate	Bernard Rabinowitz	
9A	NJEA's Position Paper on Health Care Reform and Cost Containment	Betty Kraemer NJEA	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
9B	Discussion on how hospitals (ie.Elizabeth General) are affected by uncompensated care and physicians costs	George Billington President Elizabeth General	
9C	Reimbursement to portable Providers of diagnostic services to medicare/ medicaid patients	Frederick Brotz President Diagnosiic Health Systems	
9D	A position Paper by IDS Financial Services· "Will the U S Life Insurance Industry Keep It's Promises? Solvency Issues in the 1990's"		Clay Cardinal Dept Insurance
9E	Clearer definition of the role of a local health officer	Milton Prystowsky President	
9F	Statement Paper on the Issue of Health Care Policy Planning (Preventive medicine, better management of treatment for the clinically-ill, etc)	Leon Langley NJ Pharmaceutical Association	
9G	Recommendations from the Policy & Plan Development Comt to adopt a health care system	Camilla Vance Chair PPD of the SHCC	Dr F. Dunston

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
9H	June 6th Wall Street Journal article on hospital competition in Kalamazoo, Michigan		Bruce Siegal
9I	"Health Insurance Cost Increases Lead To Coverage Limitations & Cost Shifting	United States General Accounting Office	Bruce Siegal
9J	Statement of concerns by the NJ Health Care Coalition	Al Elanoff Co-Chair	
9K	Concern that health care insurance companies must be held more accountable for their premium costs & reimbursement policies	Eileen Guerin Belford, NJ	
9L	Information on malpractice which had been added to the Insurance Reform Legislation White Paper Medical Inter-Insurance Statement		Clay Cardinal Insurance Dept
10A	Request for Uncompen- Care Task Force Items (a) Managed care for AIDS patients (b) Expedition of Medicaid applications		Charles Marciante

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
10B	Article from Medicine & Health - Perspectives Debunking Small Group Insurance Myths (Re RWJ Demo Project)	Dr Joanne Finley	
10C	Requesting an Investigation of the Axiom Group and the extravagances they expand	A concerned citizen	
10D	Indicating that family therapy services provided in health care packages is a costsavings and significant monetary impact	Perry Draper President American Associatiation of Marriage & Family Therapy in NJ Inc	
10E	Testimony on the Garden State Health Plan (6/26/ Mtg)		Thomas Russo
10F	Testimony from the Division of Medical Assistance and Health Services (6/26 Mtg)	Saul Kilstein Director	
10G	Testimony from Medical Inter-Insurance Exchange of NJ on medical malpractice (6/26 Mtg)	Howard Weiss Sr V. President	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
10H	Allied Signal Slide Presentation (6/26 Mtg)		
10I	Comments on a range of issues which have been changed to the Commission	John Forsman President Healthcare Financial Management Assoc	
10J	Foster Higgins 1989 Information and Research Package	Foster Higgins	
10K	Prudential's Position Paper	Joseph Frankel Vice President Government Affairs	
10L	Mental Health Issues and Recommendations Re Uncompensated Care, CN process, Reimbursement, etc	Gail Levenson The Mental Health Association in New Jersey	
10M	Physician Panel Copy of Comments @ (6/26 Mtg)	Dr Alvin Goldstein	
10N	Physician Panel· Copy of Comments @ (6/26 Mtg)	Dr. Michael Grossman	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
10O	Physician Panel	Dr John Capelli	Copy of Comments @ (6/26 Mtg)
11A	Copy of a dissertation research report on health care policy & studies conducted at the state levels including Canada	Ed Fox University of Washington Political Science Dept	
11B	Washington's Basic Health Plan		Dr Bruce Siegal DOH
11C	Report on Components of Health Delivery Task Force		Thomas Russo
11D	Synopsis of Health Plans Oregon, Connecticut and Canada		Diane Lynch DOH
11E	Recommended Changes in Planning and C/N Operations and Authorities		John Scioli DOH
11F	Comments and suggestions on the existing DRG hospital care system	Donald Daniels BC/BS	
11G	A written presentation to Commission on current	Joseph Sherber President Kimball Med Ctr.	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
11H	Information on State risk pools (includes statutes)	M Echevarria Mutual Benefit Life	
11I	Proposals to the Commission	NJ Chiropractic Society	
13A	Suggested programs and expert experience HIP/Rutgers can offer in reducing health care costs	Roger Birbaum President HIP/Rutgers Health Plan	
13B	Petition requesting Commission to adopt a uninformed, comprehensive cost containment plan	New Jersey Action Supporter	
13C	The Health Insurance Industry Strategy for Containing Health Care Costs Report to the Board of Directors	Health Association of America	Commissioner Fortunato
13D	Statement by the NJ Public Health Association advocating preventive health care and universal coverage & comprehensive benefits	NJ Public Health Association	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
13E	(a) Providing Access to Health Care and Controlling Costs Approaches a broad Option for the U S Including information on West Germany's healthcare system and a "Health Affairs article "Health Care Spending and American Competitiveness"	Uwe E Reinhardt Princeton University/ Woodrow Wilson School of Public & International Affairs	
13F	Business Insurance articles on current California health care reform		Assemblyman James McGreevey
13G	Statements, Editorials, and other relative info on how chiropractic services are cost effective	Arnold Ciancerilli Representative of Chiropractic Community	
14A	A study by the British Medical Journal on chiropractic treatment and costs.	J Daniel Sheeley President NJ Chiropractic Society	
14B	JAMA article on NY State's Regulatory Reform on Hospital staff supervision and Working Hours	Dr. Stan Bergen President UMDNJ	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
14C	Southern NJ Perinatal Cooperatives Testimony on the importance and need for preventive, prenatal care for women & funding for these services	Judy Dolan Executive Director UMDNJ	
14D	An analysis on the Canadian Health Insurance System and how it could be implemented in the U S	Melvin Glasser Director Committee for National Health Insurance	
15A	Report on Hospital Regulations at the Turning Point Opportunities for Change	NJHA	
15B	Information from the Assoc of Trial Lawyers of America NJ on medical malpractice	Nancy Becker Nancy H Becker Associates	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
16A	A study by Health Care Investment Analysts, Inc Competitive Hospital Markets Diffrences in Costs and Changes" Supports that normal competive forces do not work in hospitals		Ralph Dean
16B	Complaints against current hospital billing system, especially feeling it is scamming Medicare with inflated bills (Original ltr sent to U S Dept of Health & Human Services)		Adrian Fredericks
16C	Comments on BC/BS proposed bare bones package, indicating it is expensive & incomplete Suggesting a more effective effective approach through managed care		Don Gasparro Foster Higgins
16D	Provided documentation and reports on the health care issues facing America as being studied by a National Committee for Quality Health Care		Janet Renotta Sandoz Pharmaceuticals

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
16E	Packet of information from UMDNJ shared with the American Medical Assco , House of Delegates Info on HMO's Oregon's Health Care Approach the Uninsured Population, and AMA Medical Schools Also included an article from Medicine & Health. "Debunking Small Group Insurance Myths".		Stan Bergen UMDNJ
16F	Proposed plan to improve access and contain assts of NJ health care	Medical Society of New Jersey	
16G	Overview of available programs and effectiveness of the programs	Roger Birnbaum President HIP/Rutgers Health Plans.	
17A	Commission on Sex Discrimination in the statutes' preliminary report on the high cost of women who do not receive prenatal care as well as the need to promote prenatal care to all women, insured and uninsured	Melanie Griffin Executive Director State Commission on Sex Discrimination in the statutes	

#	DOCUMENT TITLE	SOURCE	INTERNAL SOURCE
20A	MHANJ efforts to document the need for equitable benefit coverage Brief recommendations for consideration by Commission	Carolyn Beauchamp Executive Director The Mental Health Association in NJ	
20B	Alcohol, Drug Abuse and Mental Health Insurance Coverage	Coalition for Comprehensive Health Care of New Jersey	
22A	A National Consensus on Healthcare for Persons Without Insurance	Jane Frances St Joseph's Hospital and Medical Center	
22B	Solutions to NJ's Health Care Crisis	HEAL	
22C	Status of the Volunteer First Aid Squad in NJ	Linda McKnight Tri-Boro First Aid Squad, Inc	
22D	NGA Health Care Conference	Governor Booth Gardiner National Governors' Assoc	
24A	Student Health Insurance Issues	Elizabeth Langan Princeton University	