PUBLIC HEARING

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

on

FUNDING UNCOMPENSATED CARE UNDER NEW JERSEY'S HOSPITAL REIMBURSEMENT SYSTEM

March 24, 1986
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Jr., Chairman
Assemblyman Thomas J. Deverin
Assemblyman George J. Otlowski

ALSO PRESENT:

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

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State of New Jersey

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE
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February 28, 1986

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE STATE OPTIONS AND PLANS FOR THE PROVISION OF HOSPITAL-BASED INDIGENT CARE IN THE ABSENCE OF THE CURRENT FEDERAL WAIVER OF MEDICARE REGULATIONS WITH RESPECT TO HOSPITAL REIMBURSEMENT RATES UNDER THE DRG SYSTEM.

Monday, March 24, 1986
Beginning at 10:30 A.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Monday, March 24, 1986, beginning at 10:30 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, to consider how the State can minimize the impact of adverse federal actions related to the existing federal Medicare waiver which allows the State to set acute care hospital rates for Medicare and Medicaid patients under the Diagnosis Related Group (DRG) reimbursement system and to include a component that reflects bad debt and indigent costs attributable to all users of hospital services.

In the present environment, New Jersey's method of funding uncompensated hospital care is vulnerable because the federal government may try to terminate the Medicare waiver, or severe federal cutbacks to Medicare may result in a State decision not to continue the waiver. In either case, the State's first priority will be to ensure that the funds needed to finance uncompensated care continue to enter New Jersey's acute-care hospital system. This public hearing is intended to focus

on possible new approaches to the financing of hospital care for the medically indigent both in the immediate future and on a long-term basis.

Address any questions and requests to testify to David Price (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit eight copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available for each witness.

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ASSEMBLYMAN HAROLD L. COLBURN, JR. (Chairman): I would like to get started. I'm sorry you are presenting your information to a Committee of one, so far. We have a difficulty on my side of the aisle. Of our two members, one of them has to be out of town, and the other one-- Oh, thank goodness, here comes Assemblyman Deverin. Now we are a Committee of two.

ASSEMBLYMAN DEVERIN: I can't get used to Republican time. (laughter)

ASSEMBLYMAN COLBURN: Well, I thought we were back on Trenton time.

ASSEMBLYMAN DEVERIN: We Democrats never start on time.

ASSEMBLYMAN COLBURN: Maybe you're wise; I don't know.

I would like to open the public hearing and introduce to you several people. One is Gloria Rankin, who is the Minority staff person over there. Assemblyman Deverin has just arrived, and perhaps Assemblyman Otlowski will be here. David Price is our staff man from Legislative Services, and he does an excellent job for us. I am Harold Colburn. John Kohler is over here. He's with the Majority staff, and Bill Nolte is on the end. He's from our legislative office in Burlington County.

I am certainly gratified by the tunout. I think it is an indication of the difficulty and the importance of the subject.

I am Chairman of the Assembly Health and Human Resources Committee, as you know. I would like to ask that those of you who have not filled out your little slips, if you wish to testify, please do so. We have some up here, and I think-- Are there some over on the chair, David?

MR. PRICE: Yes.

ASSEMBLYMAN COLBURN: There are some there on the chair in case anyone else wants to testify. So far I think we have eight or nine people who want to testify. When you do come up, when you are called to testify, if you have any

written testimony, please bring it up with you and give it to us. I think, in view of the fact that so many of us are not here today -- two of our people will not be here -- that if there is anything in writing you can present, it would be a good idea because then the other Committee members will have a chance to see it.

We are trying to ensure the continuance of compensation to hospitals, and hopefully at some later date, physicians for uncompensated medical care. You know, our State has been in the forefront of providing this, and now with changing conditions it may not be so easy.

I am going to ask Deputy Commissioner Molly Coye to come forward to start things off for the Health Department. If you will, Dr. Coye.

D E P U T Y C O M M I S S I O N E R M O L L Y J. C O Y E: Good morning, Dr. Colburn, Assemblyman Deverin. I am Dr. Molly Coye, Deputy Commissioner of Health. On behalf of the Department, I would like to thank you for scheduling this hearing and for bringing to the Legislature and the public an awareness of a problem which could have severe consequences for public access to hospital care, the issue of uncompensated care.

We at the Department of Health recognize the problem and have been working for almost a year to learn how these issues are being addressed in other states around the country. I am pleased to report that New Jersey's system emerges as one of the strongest in the nation in its protection of public access to hospital care. At the same time, virtually every hospital in the State has been able to participate in the benefits of the system, recognizing the need for all payers to share in the costs of uncompensated care.

We are going to need your help to address this issue. You should know that we have been working closely with the New Jersey Hospital Association to develop a solution to the uncompensated care problem. Our staff has been meeting

informally with payers as well, who continue to be remarkably cooperative and good-spirited regarding their role in maintaining full access to hospital care for all citizens in this State, regardless of their ability to pay.

I would like to introduce Christine Grant now, who will present the prepared remarks which you have in the black folders in front of you. Christine is the Director of the Hospital Reimbursement Program, and she has prepared the extensive testimony you have before you. I would like to point out that included in that testimony is a question and answer section as well. Hopefully, you will be able to use that in responding to your constituency who may have specific questions on these issues.

Again, thank you very much for calling this hearing. It is on an issue we are very concerned about, and we hope we will be able to provide all of the information you may need in order to come to a decision on it.

ASSEMBLYMAN COLBURN: Thank you, Dr. Coye.

C H R I S T I N E M. G R A N T: Good morning. My name is Christine Grant, Director of the Hospital Reimbursement Program of the Department of Health.

As Dr. Coye indicated, New Jersey leads the nation in financing hospital care for the uninsured. It does so through a prospective hospital rate-setting system under which all payers share equitably in the financing of care for those unable to pay. It is particularly characterized by remarkable cooperation on the part of the payers, who carry an explicit burden of payment for uncompensated care in return for the benefits of hospital cost containment.

Presently, even Medicare and Medicaid participate by virtue of a "waiver" of Federal law. The State earned this waiver as of right first in 1980 and again in 1985. However, increasing hospital price competition and recent Federal funding cutbacks to Medicare threaten to de-stabilize the

financing system, to impede access to care, and to stymie efforts to preserve and improve the delivery of appropriate care to persons in need.

The State should consider several approaches to carry the system successfully into 1990. First, New Jersey needs a financing reform to the existing system to broaden the payment base for uncompensated care at hospitals and to remove any competitive disadvantages of hospitals delivering large amounts of care to the uninsured. One approach would be to establish and implement an uncompensated care pool by statute. This reform would allocate the costs of uncompensated care more equitably and would reinforce public support for payment for care for the uninsured.

Second, there is general recognition that care in hospital-based outpatient areas and emergency rooms is, in some cases, fragmented and excessively costly. More cost-efficient relationships among hospitals, freestanding ambulatory centers, and physicians can be explored to both improve the delivery of care and contain costs.

Third, strengthened cooperation among all State agencies with responsibilities for categorical and entitlement programs would be welcome. The Department of Health sponsors numerous categorical programs for the medically indigent through Maternal and Child Health and neighborhood health centers. The Medicaid Program in Human Services provides valuable entitlement in the Medically Needy Program.

Fourth, improved data about the medically uninsured population's demographics, their medical needs, and their utilization patterns is needed.

These are the four general approaches which are appropriate.

There are several very specific short- and long-term options which can be considered to strengthen the system of care for the uninsured. Before I list the possible options,

let me explain why the current system is so threatened by Medicare cutbacks.

All payers under our system have a percentage added to the hospital bill to help pay for that hospital's bona fide charity care and bad debt. The statewide acute care hospital costs of uncompensated care are $250 million annually. Medicare pays $90 to $100 million of this; Medicaid pays approximately $20 million.

The systems and techniques used in our State are applauded by national authorities on the subject of care for the uninsured. But, the stability of this financing mechanism is in imminent danger.

The Federal government froze Medicare payments at Fiscal Year 1985 levels beginning October, 1985. This is not what was scheduled to occur under Federal Medicare law. What was scheduled to happen was at least 5-1/2% inflationary increases and higher rates. Congress was supposed to decide by November whether to increase rates on schedule. It did nothing but sustain the freeze. Three times the deadline to act has come and gone. Three times Congress has not decided what to do. Therefore, as Medicare payments under New Jersey's system are compared by the Federal government to what would be paid under their Prospective Payment System -- PPS -- the savings to Medicare which were projected are not materializing. This is causing imminent threat to the waiver because the system cannot demonstrate savings over three years if Medicare still pays a full share of uncompensated care.

It should be clearly understood that this is occurring through no fault of New Jersey's hospitals or the rate-setting system. Under the New Jersey system, 1986 inflation is a modest 5%. It is the combination of PPS rules freezing Medicare payments contrary to previous Federal law and the Federal policy of paying no share for care to the medically uninsured that are the route of the problem.

Faced with the real possibility of a State decision that continuing the waiver is not possible, and the need for the State to continue to encourage innovation and improved cost-effectiveness in delivery of care to the uninsured, there are short- and long-run options available. These options have been tried with varying success around the country.

The short-run option -- six months to one year -- would appear to be the introduction of a pooling of uncompensated care among all hospitals' rates and to transition some of the payments to non-Federal payers. These steps alone are not the desirable long-run solution. In the short run, they are necessary. The pooling concept would work as follows:

Under the existing system, each hospital collects payments for its own uncompensated care through an increase to the rates charged to the payers. While the average hospital increases its rates by about 7% for this purpose, the hospital -- technical term -- "markups" for unpaid care vary widely, with the lowest being near 1%, the highest near 25%. The use of this hospital-specific mechanism for the collection of moneys to pay for uncompensated care places hospitals with many low-income patients at an unfair competitive disadvantage as compared to hospitals with little unpaid care for which to collect. As payers and patients become increasingly price conscious -- which is, I would add parenthetically, often a prudent activity -- there can be the threat that insured patients will inappropriately avoid hospitals with high levels of unpaid care for this reason alone, leaving these hospitals with a declining source of payment for a constant financial need to provide access. Once such a process begins, it could polarize the health care system into a two-tier system of care.

The pooling mechanism -- the innovation suggested -- would require that all hospitals employ a uniform add-on to their rates for the collection of moneys to meet this statewide obligation. Under this proposal, a single statewide add-on

would be charged by all hospitals. Hospitals with approved uncompensated care needs below the statewide average would forward a net amount to a trust fund, keeping what it needs to treat poor and uninsured patients in that institution. Hospitals with high levels of unpaid care would bill the statewide add-on as well, but would receive their additional needs from the trust fund.

Under this mechanism, payers that price shop for inappropriate reasons could not avoid paying a fair share of uncompensated care regardless of the hospitals they choose, and urban hospitals and payers that do not price shop will not be at an unfair disadvantage.

In addition to a change of the collection mechanism, the proposal would call for an expanded audit to continue to protect the system against abuse, and a high level advisory committee to monitor and advise concerning the effectiveness of the audit.

These changes would keep New Jersey in the forefront of assuring the poor access to high quality care regardless of ability to pay.

The reforms described here will be supported by both the Department of Health and, we believe, the New Jersey Hospital Association. We are currently working closely with them to negotiate the details.

For the longer run, the Department of Health has been exploring, for over a year, options tried with varying successes in other states. Most recently, the Governor's office convened an excellent seminar on uncompensated care in December. State health and hospital leaders attended and heard what is going on around the country.

What are the long-run State options for uncompensated care? Based on the literature on the subject and experiences throughout the nation, the following are long-run options:

First, the State can continue to explore broad-based funding of uncompensated care beyond hospital payments only. Other hospitals have explored taxes and dedicated state revenues.

Second, states can optimize insurance coverage -- both public and private. Expanding open enrollment and keeping it within the ability to pay for recently unemployed persons, and expanding Medicaid entitlement and Medically Needy Programs are two possible approaches. Medicaid need not automatically follow suit with Medicare cutbacks.

Third, states can ensure efficient use of existing funds. This option suggests the need to consistently audit and monitor both the reporting of uncollected revenues, as well as to develop alternatives to high cost medical care by developing more effective delivery systems.

In conclusion, in New Jersey the system has worked well to date. There have been virtually no public cries of patient dumping or denial of access which regularly make front-page news in other states. However, the stability of the system is in imminent danger due to Federal cutbacks to Medicare payments.

The most obvious short-run solution is to create a pool. Its time has come, I would add, with or without waiver considerations. The State must be prepared to ask the remaining State/Federal payer, Medicaid, and non-Federal payers to assume some of the shortfall. The hospital industry must be prepared to carefully husband the valuable uncompensated care dollars they are assured only in New Jersey. They must be prepared to scrutinize whether the care is being provided most cost-effectively and where change in delivery is needed, and eliminate underutilized services wherever they exist.

The State Department of Health is prepared to continue to work with all parties to implement the pooling mechanism to further strengthen the collection procedures and take care to

prevent abuse, and to work with all payers in order to minimize the negative impact which unprecedented cuts to Medicare will have on the hospitals, payers, and most importantly, the people of New Jersey.

Thank you.

ASSEMBLYMAN COLBURN: Do any members of the Committee have a question for Dr. Coye or Ms. Grant?

ASSEMBLYMAN DEVERIN: Just one question on the idea of the pooling. You say you have met with the hospitals. Have they given their opinion on that?

MS. GRANT: You may well hear from the testimony from the Hospital Association. We have been in discussion with them, and I will leave to them their precise opinion. I would say we are pleased that we have been able to work productively with them to date.

ASSEMBLYMAN DEVERIN: Why is there such a big spread between the markups of 1% to 25%, because some are urban hospitals and some suburban hospitals?

MS. GRANT: That's precisely so. The system is set up on a hospital-specific basis, so a hospital figures its add-on to pay for its uncompensated care needs based on the total amount of revenue which it does not collect due to persons who are uninsured.

ASSEMBLYMAN DEVERIN: So the urban hospital would have the higher markup?

MS. GRANT: Yes, as might be expected, particularly large teaching hospitals in our State.

ASSEMBLYMAN DEVERIN: Is this the same in profit and nonprofit hospitals?

MS. GRANT: In our State of New Jersey, we have but one proprietary hospital, so we really haven't seen that distinction which one has read about in other states.

ASSEMBLYMAN DEVERIN: Okay, thank you.

ASSEMBLYMAN COLBURN: Mr. Otlowski, do you have any questions?

ASSEMBLYMAN OTLOWSKI: No, thank you.

ASSEMBLYMAN COLBURN: On Page 6 -- I guess you have the same numbered pages as we do -- on about the third line down, there was a question whether you said Medicare or Medicaid. It reads Medicare here.

MS. GRANT: Yes. It should be "expanding Medicaid" -- aid. That is an error in the written testimony.

ASSEMBLYMAN DEVERIN: There is another thing on there, Doctor, that is very interesting.

ASSEMBLYMAN COLBURN: Yeah, go ahead.

ASSEMBLYMAN DEVERIN: "Expanding open enrollment and keeping it within the ability to pay for recently unemployed persons."

MS. GRANT: Yes.

ASSEMBLYMAN DEVERIN: Now, you say that is working well in some other states?

MS. GRANT: This is an option which is one of the first approaches which persons familiar with the issues of uncompensated care advised the State to look at. Their argument is that the least expensive way to care for the uninsured is to minimize the lack of coverage by maintaining it for as long as possible, particularly recently unemployed coverage.

ASSEMBLYMAN DEVERIN: Who are probably the biggest body of people uninsured.

MS. GRANT: It is believed -- and we don't have the precise numbers in New Jersey -- but it is believed that recently unemployed persons do form a large portion of any state's uncompensated care population, and it is a very important issue to address.

ASSEMBLYMAN DEVERIN: That's understandable. You know, you're working, you're covered, and you get laid off and you have no income, and it's difficult to pick up what some companies--

MS. GRANT: Right. Our concern in New Jersey is that we do have payers who have made available open enrollment. What needs to be explored is the extent to which it is within the economic reach of the person who is unemployed, because they must immediately pick up the premium cost out of their own pockets, which may be problematic for them.

ASSEMBLYMAN COLBURN: Are there plans in place in other states that you can point to specifically respecting one state or another? I mean, are there any state plans that you are familiar with that we might take a close look at?

MS. GRANT: No state has the full range of options. Certainly, the New York system has tried the pulling concept. It is a more complicated, more regionalized concept than our proposal would be and we think, for good reasons, that ours is a simpler, more statewide approach. You certainly would want to look at that state.

Massachusetts also, I would venture to say, has a more complicated system of paying for the uninsured, but that is a state one would want to look at. We do have materials, as well as contacts, which we could make available to you and your Committee, if you so desire.

Regarding the notion of using other sources of revenue, and the notion of expanding Medicaid entitlement, one would want to look at states like Florida, which have had both positive and negative experiences on that subject. They have gone the route of tapping a broader base of essentially a tax on hospital revenues, and that has essentially been used to finance, as I understand it, a broader Medicaid entitlement.

ASSEMBLYMAN COLBURN: Okay, thank you. I have a question for either you or Dr. Coye having to do with whether you can think of any other efficiencies in our health care system that might offset hospital costs or costs for uncompensated care.

DEPUTY COMMISSIONER COYE: I think that-- I'm sure Christine will have some information to add on that, but I think in the short run we can look for increased efficiencies in the collection of revenue. The Department has been working with hospitals which have a very high burden of uncompensated care to improve their collection and accounting. From that point of view, long run, the best efficiency is prevention. As we get, in other hearings, into the area of maternal and child health, I hope we will be able to demonstrate that by developing new programs which will prevent infant mortality and low birth weight, that we will be able to avoid some of the high expenditures for high risk births and adverse outcomes that now are experienced in the system. If I understand correctly, approximately 40% of the uncompensated care costs in this State surround prenatal care, births themselves, and care for the infants afterwards.

There is good literature to suggest that you can effect substantial savings on the order of spending one dollar to save between two and three dollars. If we could achieve even a proportion of that, we would save a substantial amount of uncompensated care. So, yes, I think there is significant efficiencies that we could address. Christine may want to add something.

MS. GRANT: I would add that in addition, certainly, to the prevention issue which would impact directly on those who are poor and uninsured themselves, there are other parts of the system which the Department has been looking at for almost a year, and we will continue to look at that. Particularly in an era of declining hospital admissions, it is incumbent upon the Department to scrutinize the extent to which the full cost of indirect costs are paid to hospitals that have substantially declining volumes.

Our Assistant Commissioner, Mr. Morris, is responsible for those activities. I would defer to him to go into

specifics, but certainly the Department is looking at declining volumes. We are, frankly, also looking at the issue of the extent to which there is substantial capital expenditures in the State now and in the future because, in fact, there are trade-offs between our resources paid for the three major areas -- the four major areas -- the direct patient care, the uncompensated care, the capital costs of care in our State, hospital costs, and, of course, the graduate medical education costs. Those are the big costs of hospital care.

ASSEMBLYMAN COLBURN: One thing that has struck me over the years is the question of the cost of regulating the hospital as it has to do with audits and things for Medicare and Medicaid, whether all of these regulatory things might be combined so that they only have one visitation instead of several. Now, I don't know to what extent that might contribute to the costs. I was going to ask you about it, and I was going to ask the Hospital Association, too, what they think about that.

MS. GRANT: Assistant Commissioner Morris did institute a common audit with Blue Cross, so the Department of Health, in fact, does subcontract with the audit staff -- it happens to be a fiscal intermediary audit staff -- to do a common audit. That was one efficiency. We also have the same people doing the uncompensated care audit. I think it is an excellent suggestion and one which, if he were here, Mr. Morris, I believe, would say we have to continue to scrutinize to make sure that we are most efficient and effective about it.

ASSEMBLYMAN COLBURN: Okay, thank you. Are there any further questions from the Committee? (negative response) Thank you very much.

Next I would like to call Mr. Russo. Is Mr. Russo in the crowd, from the Department of Human Services? (affirmative response) Good morning, Mr. Russo.

T H O M A S M. R U S S O: Good morning, Mr. Chairman, Assemblymen, members of the Assembly Health and Human Resources Committee. My name is Thomas M. Russo. I am the Director of the Division of Medical Assistance and Health Services in the Department of Human Services. Essentially, that Division has the responsibility for administering the Medicaid Program for the State.

Before I really discuss uncompensated care, I would like to take a very brief moment to explain the differences between Medicare and Medicaid as they are related to the DRG system, because they are not exactly identical and I think one must understand that difference.

The DRG Program under Medicare has a Federal waiver which permits it to utilize an uncompensated bad debt factor and to receive Federal funds for that. Under the Medicaid Program, there is no Federal waiver. The Medicaid Program operates under what we call an Approved State Plan. It's a plan that has described a hospital reimbursement system for Medicaid that has Federal approval. So, technically, there is no waiver for Medicaid. If, for whatever the reason may be, the DRG waiver under the Federal approval were to be discontinued, the discontinuance basically would be under Medicare. Medicaid would still be operating under an Approved State Plan that at the present time includes Federal reimbursement for bad debts and uncompensated care.

Theoretically speaking -- and I am theoretically speaking -- it might be possible for Medicaid simply to continue what it is doing, assuming we have the existing DRG system running in place without the Medicare piece. That's theoretically. In reality, I think the Feds would question their continued support of uncompensated care under that kind of a scenario. But I wanted to make that point clear because I think it is a distinction that should be understood. The reality of it-- I believe that if Medicare were to discontinue

the waiver, the Medicaid Program would equally have a problem in receiving Federal matching funds to pay for bad debts in uncompensated care.

ASSEMBLYMAN COLBURN: How about capital? Does that enter in at all to Medicaid?

MR. RUSSO: Well, actually, Medicaid is using exactly the same system that Medicare is using, and how capital is handled under DRG under Medicare is basically how it is handled under the Medicaid Program as well at the present time.

The Medicaid Program itself, at the present time, pays about $4 million -- that's total State and Federal moneys -- for inpatient hospital care.

ASSEMBLYMAN COLBURN: Four million?

MR. RUSSO: Four hundred million.

ASSEMBLYMAN COLBURN: Four hundred million, okay. You said $4 million.

MR. RUSSO: Oh, I'm sorry.

ASSEMBLYMAN COLBURN: That's okay.

MR. RUSSO: I wish we were paying that in a way. It's $400 million for both inpatient and outpatient hospital care. This is split between about $317 million for inpatient, and about $84 million for outpatient care. Approximately $17 million to possibly $20 million of that represents Medicaid's share of the uncompensated care portion. Medicaid total hospital expenditures in New Jersey range around 9%, possibly 10%, in that area.

If the Medicaid waiver were lost, there could be several implications, as I briefly explained before, to the Medicaid Program. Medicare would probably reimburse hospitals under the national DRG system, which is called the PPS system, which, with continued tightening at the Federal level of that system, possibly could mean that the Medicare payments could be lower than Medicaid payments.

Medicaid, in all probability, would not be able to cover the costs of uncompensated care, since Federal regulations require Medicaid payments to be no more than that which is paid under the Medicare Program. That is a basic tenant of these two programs. If you have two payment systems, one under Medicare and one under Medicaid, Medicaid is required -- Medicaid being the State-funded part of the program -- to have payments that are below, basically, what Medicare pays. We cannot exceed those payments.

In addition, we would probably have to develop a different reimbursement methodology, although it is possible we may be able to use, with the concurrence of the Health Department and so forth, the existing system, although that would probably have to be totally relooked at in terms of an all-payer system.

Although we probably could not include the costs of uncompensated care in Medicaid reimbursement rates, we would be reducing the total amount of uncompensated care through the Medically Needy Program. As you know, we have a law in New Jersey -- Assemblyman Deverin was a primary sponsor of the bill -- that will become effective on July 1 of this year. As a result of that legislation, if the DRG waiver did not continue, the Medically Needy Program, based upon the law, would immediately have to provide both inpatient hospital care and outpatient clinic and emergency treatment for true emergencies for the aged, the blind, the disabled, and children. There is a provision, as I am sure you know, in the Medically Needy legislation, that says essentially that if the DRG waiver is lost or discontinued, the Medically Needy Program will automatically have to pick up that portion of hospital care. As long as the DRG waiver is in effect in New Jersey, the Program does not have to pick up that part of the care.

The projected costs of providing these hospital services to this additional population would be around $109

million. Again, that is both Federal and State shares. These costs would be offset, in part, by the $17 million in savings, since Medicaid would no longer pay for the uncompensated care part.

Expanding the Medically Needy Program to cover outpatient services will also require the Medicaid Program to limit outpatient services to clinic services and to emergency room services for injuries or significant and acute medical conditions. Again, that is required in the statute. In other words, the Medically Needy statute would not authorize Medicaid to pay under the Medically Needy Program for all types of outpatient hospital care. It would be limited to clinic services and to emergency room services for injuries or significant, acute medical conditions, which would require some definition and defining. That would have to be developed.

There is another part of the Medical Needy Program that could affect this, and that is the group that we call "Caretaker Relatives." Basically, they are the mothers or legal persons who are responsible for caring for the children. Now, at the present time, they are not included in the Medically Needy law. They could be included, but that, again, would require new legislation. It would require an expansion of the Program.

ASSEMBLYMAN DEVERIN: They were included.

MR. RUSSO: They were at one time, but they are not in the current law. That would bring in another group for whom the State of New Jersey could possibly receive Federal moneys, in part, which we are not receiving now.

The other thing I would like to mention, and I think Dr. Coye and Ms. Grant spoke about this, is the uncompensated care pool, which seems to be a logical approach to providing some funds for this part of payment for hospital care. But I think there are some other things we might want to consider as well. I do not have this on my talking points, but one is the

fact that there are persons who use hospital services today, especially in the emergency room area, basically because there is not in place equally, in all sectors of the State, a good primary physician care system to care for Medicaid patients. We have some areas of the State where we have shortages of physicians and other types of primary care providers, and for this reason many persons are forced, by habit or for other reasons, to use hospitals for primary medical care.

It would probably be most helpful if we could strengthen our primary medical care system in this State in order to encourage and promote as many Medicaid persons -- not only Medicaid, but other sectors of our society here in New Jersey -- not to basically use hospitals when that same service is available in a physician's office at a much lower cost, where the care is not episodic, where you have a regular physician to go to, and where probably the quality of the care in the long run is going to be better than the episodic type care that one might receive in a hospital outpatient setting.

The more we can foster that, I think the more preventive care we probably will have in New Jersey, and the less use of hospital services will be made. Again, in the Medicaid Program-- Medicaid currently has about 500,000 eligible recipients. With the advent of the Medically Needy Program on July 1, there will be an additional 200,000 persons added to those rolls, which will bring the total Medicaid eligible population up to around 700,000 persons.

To receive the health care related to hospital services, basically these people all have to see physicians first because the physician is the one who basically admits to a hospital setting, whether it be an inpatient or outpatient setting. We have a problem in Medicaid, quite frankly, with reimbursement fees to physicians, which does not really encourage primary medical care in the physician's office. Currently, the Medicaid Program reimburses a non-specialist

physician $7.00 and a specialist physician $9.00 for a routine office visit. Many physicians will not see Medicaid patients for those fees, thereby creating a problem of access to primary medical care, and forcing many Medicaid clients to use hospital outpatient services out of necessity. In some cases, out of choice; in other cases, it is out of necessity. I think this is an area that you may want to consider when you are considering the total cost of providing hospital services in the State of New Jersey.

Essentially, I think those are the primary areas that I wanted to mention for your deliberations. I certainly would be glad to respond to any questions you may have.

ASSEMBLYMAN COLBURN: Gentlemen? Mr. Deverin?

ASSEMBLYMAN DEVERIN: Tom, I was very interested in the emergency room. You know, whenever I meet with a hospital, the first thing they talk about is their emergency room. I don't quite understand why so many people use it for everything, cut fingers, you know, headaches. Is that a big portion of the uncompensated cost in a hospital?

MR. RUSSO: Well, I think it certainly adds to it to some degree. I'm not saying that the hospitals are at fault. I think the hospitals are definitely--

ASSEMBLYMAN DEVERIN: Oh, no, no. On the contrary, the doctors are at fault.

MR. RUSSO: --serving a public need. They are serving people who need this medical care. But, because it is episodic, it is not the best preventive type medicine we can practice.

ASSEMBLYMAN DEVERIN: You know, the point I am trying to make, Tom, is, you're right, the doctors are primarily responsible for some of the people who use emergency rooms. I can cite you 10 cases that people have talked to me about, where they were regular patients of a doctor, and it was after office hours, or close to closing an office. They would call

and ask if they could get in to see the doctor, and his nurse, or his wife, or whoever the hell runs the office, would say to them, "Go to the emergency room. We'll try to get there later." That is the kind of stuff I hope you're talking about. That's what I am talking about. There has to be some way to make the doctors more available. Excuse me, Doctor. I don't mean you. I know you're there all the time.

ASSEMBLYMAN COLBURN: I'll have my day.

ASSEMBLYMAN DEVERIN: But it seems to me that whenever I go to visit an emergency room, whenever I go to a hospital, or if I go to Elizabeth General or somewhere, and they take me on a tour, the emergency room looks like a madhouse. There are so many people being treated in there, and you find out why. Either they are non-insured -- that is the first reason they come there; they can't find a doctor -- that is the second reason they come there; or, it is the most convenient place for them to come.

From what I have gathered from my conversations, a lot of those costs are never reimbursed to the hospital. That is one of the big problems they have -- uncompensated payments. I agree that one of the things we ought to do is find some way to make-- I know around my neighborhood the 24-hour medical offices, where they have two or three doctors in a medical group or medical service group, are springing up all over the place. People are using those rather than using an emergency room, and they take their Blue Cross and Blue Shield. I don't know whether they take Medicaid or not. That I'm not sure of, but they take the rest of them.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Mr. Russo, you were talking about the fact that it would be more efficient if we could utilize doctors more than we do at the present time, and that it would be less costly -- at least you expressed that hope -- in view of the fact that doctors will not take Medicaid

patients because of the little amount of money. It's the price. A good pizza pie today runs about $9.00 after 11 o'clock at night. But, if they won't take the patient for $9.00, how will you save money? How will money be saved if they go to the doctor directly and short-circuit the hospital?

MR. RUSSO: Well, basically because-- If I had a child at home, and the child was running a temperature, say about 103 or 104 degrees, I would be concerned. I would probably want a physician to see that child, or to make some sort of a diagnosis. If I did not have a family physician of my own to go to, the only place I could go would be to the hospital because they are there and they are available 24 hours a day. I would take my child to the emergency room. They would provide a service to me, or to the child, and there would be a charge for that. The charge would vary depending upon the hospital that was being utilized. It could be, you know, $60.00, $70.00, $80.00, $90.00 for that visit, which is a primary office visit.

If I had a family physician, and I called my family physician, he may say, "Come over and see me," or "I'll come out and see you," or "See me in the morning, but in the interim do this." The cost of that care, at least under the present Medicaid system, might be $7.00 or $9.00, as compared to $70.00, $80.00, $90.00 for the same visit in the hospital setting. So, there is an additional expense in using a higher cost form, or a higher setting where the cost is greater.

ASSEMBLYMAN OTLOWSKI: The thing that Assemblyman Deverin talks about, this group practice which would allow a doctor more flexibility, and possibly not only the flexibility but the availability to a program such as you are talking about, are there any plans to encourage that kind of practice to fit into the total needs that are appearing?

MR. RUSSO: Well, the Medicaid Program does contract at the present time with two HMOs -- Health Maintenance

Organizations -- in the State. We are negotiating with a third HMO, and hopefully we may have a contract in about July of this year. The Medicaid Program, as you know, Assemblyman, has its own sort of HMO Program. It is called the Medicaid Personal Physician Plan, and is a prepaid capitation program for physicians who function as case managers for Medicaid patients. But, basically, the number of persons enrolled in those programs is relatively small compared to the total population of Medicaid eligibles, which is 700,000. It's a small group. They are good. They should be encouraged, but they are slow in growing in New Jersey, although I think the HMO concept and the prepaid capitation concept are becoming more familiar in the State. They are growing. You see them on national television; you see them in the newspapers in full-page ads today, which didn't exist three or four years ago. So, I think more and more persons will be thinking in that mode in the future as we move along. That type of care is less costly than the normal type of fee-for-service care.

ASSEMBLYMAN OTLOWSKI: One other question. As you see this, the total cost for the gap in Medicaid, the Program for the Medically Needy which will become effective in July, what kind of money do you see needed here? How much, roughly? I wouldn't hold you to any figure.

MR. RUSSO: If the Medically Needy Program were to pick up a part of the compensated care, I believe I project--

ASSEMBLYMAN OTLOWSKI: How much money would the State have to make available for these programs we are talking about, for the implementation of the Medically Needy Program, the Medicaid money, the Medicare money? How much money are we talking about, $400 million?

MR. RUSSO: In round figures, $50 or $55 million, I think, in State moneys, if the Medically Needy Program were to pick up the hospital care portion for those who are currently covered in the Program in the absence of a DRG waiver.

ASSEMBLYMAN OTLOWSKI: You're saying that it would be a total of about $55 million of State money. Isn't that right?

MR. RUSSO: Yes. That would include both inpatient and outpatient hospital care.

ASSEMBLYMAN OTLOWSKI: That money would have to come from what source, in your opinion, general revenues? Where would it come from?

MR. RUSSO: Well, it would have to come from some revenue base in New Jersey. My guess is that it would probably have to come from a general revenue source.

ASSEMBLYMAN DEVERIN: It would also be matched, Tom, by the Federal government? It's a matching fund?

MR. RUSSO: The inpatient/outpatient services would be matched by the Federal government. The uncompensated care part of it probably would not be. So, if the uncompensated care part is $17 or $20 million, that total amount would have to come from State aid, since there would be no Federal moneys coming in.

ASSEMBLYMAN COLBURN: Are there any further questions from us? (negative response) Mr. Russo, I wanted to ask you, under Medicaid as it presently exists, payment to the hospitals, I guess, as it is now, is considered adequate for what the hospital does for inpatient care. There are no deficits, I guess, in what Medicaid is providing to hospitals right now for inpatient care.

MR. RUSSO: The Medicaid Program operates under the DRG system for inpatient care, and is one payer in the system in addition to the Blues, the Medicare, and the other insurance companies, plus the self-payers.

ASSEMBLYMAN COLBURN: Okay. I just wanted to get that straight. I remember, I guess it must have been 15 years ago, a Dr. Chase in our Medical Society of New Jersey House of Delegates, pleading for Medicaid support for practices such as his in Newark. At that time, Medicaid was pretty much

financing hospital outpatient visits, but not visits in doctors' offices, you know, because the amounts were so small. I think had there been decent compensation, at least in the cities at that time, people like Dr. Chase could have provided very good care and it wouldn't have all gone to the hospitals. I can remember him pleading with us to support him, and I guess many of us didn't have the foresight or understanding to really get behind him at that time.

I also remember another situation at Cooper Hospital, where one of my friends was a physician. He called me up and he said, "Harold, if you ever get any influence in the government, please try to stop these people from going to our accident ward in the morning, Lady of Lordes in the afternoon, and West Jersey at night, all for the same complaint, and every one of them reimbursed under Medicaid." Now, of course, you see, there are lots of things on all sides of this question of availability. I think the Medicaid system itself has probably fostered the Medicaid mill because nobody can afford to treat large numbers of Medicaid patients without doing it just that way. I know a lady who was secretary to a physician in Camden, and she told me he took pains never to treat anybody who was sick. The minute they got sick he sent them to the hospital because he was getting $5.00 a visit. He would run them through, but when they got sick he had to punt.

You know, these are defects in the system which those of us who now know more about it ought to do something about. It doesn't necessarily take a complicated HMO type of arrangement to overcome some of these problems. Really, we could have done something about the emergency room visits a long time ago.

I might also tell you, Mr. Deverin, that physicians are going to be in such oversupply shortly that they will be making house calls, jumping into those docs in the boxes, and doing everything else to make everybody feel better.

ASSEMBLYMAN DEVERIN: I won't live long enough to see that. (laughter)

ASSEMBLYMAN COLBURN: I think the way we're going, we're going to prolong your life so long that you will see it.

MR. RUSSO: The point I am really trying to make, Mr. Chairman, is, I know this hearing is on the DRG Program, what might happen if the waiver is discontinued, and how we might handle uncompensated care, but I think that the more we can do in this State to foster a good primary care system in a physician's office setting, the more we can keep people healthy longer and keep them out of the hospitals as long as we possibly can, or the outpatient area, and then we won't have as much of an uncompensated care problem.

ASSEMBLYMAN COLBURN: I think you're pointing out some common ground, with the Chairman anyhow. Okay, well thanks for--

ASSEMBLYMAN OTLOWSKI: Mr. Chairman, just one thing. You know, I'm so interested in Deverin's longevity. I want him to live a long time.

ASSEMBLYMAN DEVERIN: So does Deverin.

ASSEMBLYMAN OTLOWSKI: The Doctor said something that I would just like to expand on for a moment. The one thing I have learned from watching lawyers in their practices is that it is very difficult for a single lawyer to operate in a single office today because of the economics of the whole structure. The day of the single lawyer, who was not only a lawyer, but a philosopher and a neighborhood friend, is a thing of the past if a lawyer is going to make a living.

It seems to me that the same thing applies to doctors today. The doctor as a single practitioner just can't fit into the economic structure. That's why I was asking what is being done to encourage doctors to group and to form, you know, multiple office practices.

Do you see that as one of the factors in dealing with medicine, notwithstanding the fact that the Doctor-- Our Chairman is very optimistic that there are going to be a lot of doctors, you know, which, of course, caused some concern with Deverin that it wouldn't be timely enough. But, in any event, in that whole picture, which I think is pertinent to what we are talking about here in the overall approach, what do you see with regard to that single practitioner fitting into the cost structure that we are talking about here?

MR. RUSSO: I think your observation is 100% correct. This is something probably you should be talking to the New Jersey Medical Society about, not me as a layman. But, from my observation as Director of the Medical Assistance Program, there are fewer and fewer physicians who are in solo practice today. More and more physicians are in some group type of setting. I think that is a trend that will continue for the very reason you cited. It is basically an economic reason. It's a matter of having 24-hour coverage. It's a matter of having some time off and having someone cover you when you are doing some continuing education somewhere where you have to be away for several days. That is a trend that I believe will continue. I think we will see fewer and fewer solo practice physicians in the future.

ASSEMBLYMAN COLBURN: Thank you. Are there any more questions? (negative response) Mr. Scibetta, from the Hospital Association, are you here? (affirmative response) Good morning.

L O U I S P. S C I B E T T A: Mr. Chairman, I'm Louis Scibetta from the New Jersey Hospital Association. I want to thank you and the members of the Committee for the opportunity to spend some time with you. I have with me Dom Camisi, who is Vice President for Financial Services, and Craig Becker, who is our Legislataive Liaison, Vice President of Legislative Services. I would note parenthetically that it takes three

gentlemen to take the place of the two ladies who started this testimony, but we will do our best.

I would also like, if I may, to deviate from my prepared text. You have the text in front of you, and I hope it will be reviewed. But, in the interim, for a few minutes, what I would like to do is just take a little bit of time to talk about where I see us going based on where we are at the moment, because I think that might be more valuable for your purposes.

First of all, let me say that I think-- We believe we have a pretty good system right now, and we are concerned about preserving it. It's especially a good system for the public because the public doesn't have to concern itself as to whether or not it has access to important health care services, and that is an ingredient that has been extremely important to the hospitals in this State.

The loss of the waiver can lead to two problems. One would be defined, I think, as the loss of care to the poor; and secondly, it could lead to the insolvency of hospitals. So, obviously, we would hope that any action you would concern yourselves with would deal basically with addressing those two problems, making certain that the care to the poor is maintained and that the hospitals are maintained in a solvent position.

How did we get to where we are now? Basically what happened in 1978 -- for many of you who were with us at the time when the whole reimbursement system changed-- From '78 to '80, there were decisions made relative to the changes in Chapter 83 that led to the establishment of the Rate Commission and, in effect, gave the Department of Health the authority to review every budget for every hospital, approve costs, and then have the Rate Commission establish rates that hospitals would be paid based on those approved costs. For the years 1980 through '85, Medicare, which is the subject of this based on

the waiver provisions, basically agreed to pay us on the basis of the DRGs that the costs were allocated to, rather than on a per diem basis, as they had paid before. In effect, as you heard, they used the State's methodology, rather than that of Medicare.

What happened in New Jersey during that five-year period was a continuation of what had been happening up to that point in time. Basically our costs rose at very moderate rates, and accordingly the payments to hospitals rose at the same very moderate rates over the course of each of the years. Annually, the Department reviewed the budgets, the revenues that could be paid to hospitals were approved based on those reviews, and by '85/'86, New Jersey's costs -- and this is identified in my statement -- rose the least rapidly of any state in the nation, including the District of Columbia. So, we are now, compared to all other states in the United States and Washington, D.C., the lowest in the areas of rates of increase and rates of increase of revenues to hospitals over the years. Some would say we are in the unenviable position of having reduced both our costs and our ability to survive with less revenues at a time when Medicare decided to pay everybody less than our present costs. That is the dilemma you have asked us to talk about, in effect.

Well, what is the problem in New Jersey? I mean, every state in the nation has the same problem. The fact is, they don't. In other states, hospitals have little or no problem because what Medicare doesn't pay to their hospitals they simply pass on to other payers -- cost shifting, revenue shifting, whatever you want to call it. You've read about it. Or, you've also read about the fact that they determine the ability of the patient to pay the bill before the patient is allowed to be admitted to the hospital, and perhaps they may send the patient somewhere else. You've read about what is happening in Texas, Louisville, Kentucky, and other places,

horror stories, but very real ones, where patients have gone to multiple hospitals before they were admitted.

We don't have that taking place in New Jersey; we have all been able to hold our heads high. But, since they have had no Rate Commissions, they have had no cost controls established by the Departments of Health or other agencies, those hospitals charge what they can to whomever can pay it. Essentially, they have been able to save money for a rainy day, to plan their survival, and to take care of whatever other costs they may feel they can or should based on the availability of some of their revenue.

Well, in 1986 in New Jersey, those decisions, that is, basically on the survival of hospitals, are now largely going to be shared between the Department of Health and their decisions and the New Jersey Legislature and, fortunately for us, we have been asked to be a part of both ingredients, and we hope to be a part of the solutions.

I think we all agree that we will lose the waiver. It is just a question of when. Moreover, Medicare will continue to pay less. So, hospitals can't shift their charges to others. They have little or no ability to continue to decrease their costs of operation. Their surpluses are little and inadequate for both care to the poor and to provide funds needed for future capital, for renovation technology, and just for change.

In effect, the Hospital Association's approach is really quite simple. What we are suggesting is, first of all, establish a financial pool, or a fund, similar to that which was described by Dr. Coye and Ms. Grant. Into this fund hospitals will pay or receive money for a combination of indigent care and bad debt services, lumped under the heading of "Uncompensated Care." It would require all payers, including Medicaid, to increase what they pay so that the costs of care to those who are poor and to those who are bad debtors

are covered, as is the case at the moment. And third, we would prefer to include into the ingredients of the pool, a dedicated tax from New Jersey -- some have even suggested a tobacco tax -- to assist in meeting these costs and to assure New Jersey's continued social commitment for uncompensated care to all, regardless of the ability to pay.

So, in summary, we have no doubt that we will lose the waiver. We believe you will end up -- we hope -- with a structured approach from both the industry and the regulators; that is, the Hospital Association, the Department of Health, and many others who have a real concern about care to the poor and about financing our hospitals, including the payers, a structured approach, we hope, so that we can then lean on your leadership, and somewhat quickly.

I would like, for the record, to indicate that from my personal point of view, pooling is normally a terrible way of meeting hospital revenue needs. I think, however, in this instance, that this one form can be justified to be compatible with increased competition, although a pool should never be used for other than uncompensated care.

Finally, I would just say that we are grateful. I am proud of your continued leadership in recognizing the seriousness of providing health care to the poor and needy and maintaining the solvency of hospitals. Certainly the passage of the Medically Needy bill, which Assemblyman Deverin is primarily responsible for in this State, is a model. We look forward to working with all parties and providing a reasonable response to what could become a critical problem if, in fact, all parties who can provide solutions are not equally dedicated to the same kind of answers.

I would be happy to try to respond to any questions you have, gentlemen. I have indicated, also, that Mr. Camisi and Mr. Becker are here to assist in that regard as well.

ASSEMBLYMAN COLBURN: Mr. Otlowski, any questions?

ASSEMBLYMAN OTLOWSKI: Are hospitals in financial trouble today?

MR. SCIBETTA: I believe the answer to that would have to be that some hospitals are in financial trouble today. Specifically in New Jersey, hospitals have had a system which does not allow them to either accumulate a great deal of wealth or, to date, be deposed from operating their facilities and their services. There has been a fine line maintained, that in return for controlled costs and controlled revenues, on the basis of Chapter 83, hospitals have been held solvent. So, there is a fine line, Mr. Otlowski. They don't have much in the way of resources, although you don't see-- In New Jersey, because of the system that has been designed and implemented, you don't see either wealthy hospitals or hospitals that are in disaster.

ASSEMBLYMAN OTLOWSKI: Why, in your opinion, are hospitals consolidating, merging? Is that part of the financial problem they have?

MR. SCIBETTA: I think there is a movement nationally for systems -- hospital systems -- to develop. I think it is probably a result of a number of activities taking place, and at the head of those I would say competition, in general, is at the peak of it. There is a tremendous amount of competition, which is kind of ironic in our system because New Jersey has in effect a public utility model which is not supposed to be a free market enterprise system. Some think we have the worst of the best systems; that is, the only two systems we know, the free market system and the public utility market.

ASSEMBLYMAN OTLOWSKI: But, if hospitals are quasi-public utilities, or even utilities, and at the present time they are being goaded by competition to merger-- Is that a healthy thing, to be goaded by competition into mergering to save themselves, or to become bigger so that they can cope with the problem? Is that a healthy thing in your opinion?

MR. SCIBETTA: Well, I would say that a certain amount of collective activity on the part of our hospitals is a healthy thing, particularly in an environment which has changed; that is, an environment of downsizing, utilization being what it is, and the Federal government doing what it has done, saying, in effect, "We aren't going to pay for you to go to the hospital any more, period." They haven't concerned themselves a great deal with a social conscience, in our opinion. They simply said, "We aren't going to pay any more. You find another way to take care of patients." That means don't put them in a hospital, A, and B, get them out quicker, because the recovery of those patients is not going to be taken care of in a hospital.

Now, you add all of these collective activities together, plus the fact of Medicare simply unilaterally deciding that they are going to pay considerably less, regardless of what the costs of providing the services are, and you have yourself a real dilemma, which we are experiencing in New Jersey and all over the nation, which you are reading about, and that is, hospitals are not utilized to the same extent that they were. The hospitals are doing, I think, very responsible things in responding to the realities with which they have to deal at the time. These realities are considerably different than they were ten years ago, or five years ago, or for that matter, even three years ago.

ASSEMBLYMAN OTLOWSKI: If there is -- and I have no argument about it -- under-utilization in many hospitals-- I think we are agreed that a number of hospitals are faced with under-utilization of beds.

MR. SCIBETTA: We would characterize it as less utilization. I don't know what under-utilization means. I think that is the issue we are going to be dealing with in the next year.

ASSEMBLYMAN OTLOWSKI: Well, I suppose for that differential you would have to have a master's degree, and I don't have one. But the fact is, if a bed is empty, it is either being less-- Well, it is not being used, frankly, if it is unoccupied. But in any event, that is something that is emerging today, the non-use of hospital beds. Isn't that so?

MR. SCIBETTA: Absolutely.

ASSEMBLYMAN OTLOWSKI: In view of the fact that there is a greater need for medical care today, isn't that an unusual thing to have beds empty, not used, less used? Isn't that an unusual thing, when we are looking for methods and means of getting treatment to people? Isn't there something cockeyed there?

MR. SCIBETTA: Assemblyman, I think you're touching on a subject that I couldn't agree with more. It is a relatively recent phenomenon that here we have less utilized facilities, and we're not sure how far it is going to go. In New Jersey, we need to look at things such as how we can use these facilities differently. What are our needs that haven't necessarily been addressed, and how rapidly and how with the least amount of bureaucracy can those hospitals make decisions that will, in fact, respond to the needs of the public in different ways than they have?

I'm proud to say, as a resident of the State of New Jersey, that I think the Department of Health has that attitude very much in mind. Hopefully, we are going to work with those issues in mind with the regulators and with yourselves over the period of the next year or two, to see what kinds of systemic changes might need to take place.

On the subject of physician availability and facilities at the same time -- you talked about that a little earlier -- when Commissioner Albanese was Commissioner of the Department of Human Services, I served as Chairman of the Hospital Cost Containment Committee that he appointed, and one

of the suggestions-- I think one of the initial recommendations we made that was endorsed was that when you have such an urbanized setting as New Jersey represents-- There are areas in the State -- and everybody is aware of them -- where it is just simply not safe to be late at night. Those areas have a huge influx of people who need emergency, and sometimes not so emergent care, and they go to their hospitals. Doctors are not safe in their offices and, at the same time, you have hospitals in those particular areas that aren't being utilized to the extent that they were in the past. The suggestion came, let's perhaps consider using some of those facilities, converting them to, in effect, doctors' offices, if you will, and, in effect, promoting hospitals and physicians to joint venture, to work together, whatever you want to call it, in those areas to take care of the poor in the most efficient setting as possible. Right now the alternatives are quite limited, and in the foreseeable future probably will be. This is certainly much different than the kind of problem they face in Wyoming and Nebraska, but it is because of the urbanization of our State and our hospital system.

ASSEMBLYMAN OTLOWSKI: One other question. In the Federal report that was just issued here recently-- Frankly, I don't know how accurate the report is, whether it just makes good newspaper stories or, you know, whether somebody has a particular ax to grind or, you know, the depth of the report, so I don't want you to think that my question is asked out of any expertise or that I have a fixed opinion about this. The Federal report indicated there were a number of hospitals that weren't giving older people proper care -- at least the report indicated that -- and that their debts were probably accelerated in some hospitals in comparison to other hospitals.

In your opinion, does that have any relationship to this whole business of Medicare and Medicaid -- the urban hospital that is overloaded? Are you familiar with the report I am talking about?

MR. SCIBETTA: Yes, sir, I am very familiar with the report you are referring to, and I appreciate--

ASSEMBLYMAN OTLOWSKI: Is it related to, you know, what we are looking for here? Is it related to Medicaid? Is it related to Medicare? Is it related to what you and I see-- You see it as the -- what is it? -- the unused bed. I see it as the unused bed; you see it as the empty bed. But, is it related to any of this we are talking about?

MR. SCIBETTA: No, sir, I think it is related to absolutely nothing except that it sells newspapers.

ASSEMBLYMAN OTLOWSKI: It what?

MR. SCIBETTA: It sells newspapers. If you carry the logic of the information, which doesn't really deserve the classification of data, to its logical conclusion, the hospital that would make certain that it never admitted sick people would have the finest record in the world. When you look at the data that was spewed across the newspapers, it included hospices, which are where people go to die, and indicated that they had a lower mortality rate than they were supposed to have. I mean, 87% of the people who went to a hospice died. So, if you combine that with the words of the gentleman who, at least as of last week, was the Acting Administrator of the Health Care Financing Administration, who released the data, who said that the data could be used for no conclusions, I think it deserves just about that much attention.

ASSEMBLYMAN DEVERIN: He also didn't tell you why he released it. I agree with you. It is the silliest thing I ever read in my life.

When Dr. Goldstein from the Department of Health was here, he testified very much similar to what George was just asking. The hospitals are over-equipped; there are too many empty beds; there are too many rooms, and so forth and so on. I gathered from his conversation that something has to be done about that to cut some of the costs of hospitals down. If you

have 400 beds and you are only using 200, the costs of operation are higher than they should be. If you used those 200 beds for something else, or if you did away with them completely, your costs would be down.

Do you find that in general there are many hospitals, as George said-- For instance, do we have too many hospitals that do open heart surgery, too many hospitals that have mental health clinics, too many hospitals that have that big machine they stick you through, whatever you call it? What do you call that damned thing?

MR. SCIBETTA: CATSCAN.

ASSEMBLYMAN DEVERIN: Yes, the CATSCAN, or are there too many hospitals which expanded in the '70s, which are now finding themselves, with the new rules-- The new rules confuse the hell out of me. You know, you have to get two opinions to go to a hospital now. A friend of mine has a prostate problem, a very serious prostate problem. His doctor sent him to a urologist, and the urologist said, "Yes, you have to go for an operation, and very shortly, as soon as you can." His family doctor who sent him there agreed. So now he had two opinions. That wasn't acceptable, and now he has to go to another urologist to get an opinion because the family doctor's opinion wasn't good enough.

So, I can see why there are so many empty beds. You have nobody to put in them. They don't let you in the darned place. Mr. Scibetta, do you think that if you really cut down on stuff like that it would really help the costs of hospitals?

MR. SCIBETTA: Assemblyman Deverin, I think, first of all, we should recognize that we have less beds in operation now than we did in 1970. Our utilization is going down, so we have less utilized beds than we did, but overall our occupancy rate in our hospitals in New Jersey, compared to the rest of the nation, is really not a terribly significant issue. But there are less utilized beds now than there were in the past.

The reason is that patients are staying for shorter periods of time. In spite of all the constraints you have addressed very appropriately, admissions to our hospitals, because our hospitals have been under such very tight regulation for years, are maintaining about the same level. They have varied very, very insignificantly. They are at about the same level. The fact is, people are being discharged so early that the lengths of stay are lower and, therefore, the number of people in a bed at any given time are less, but the admissions have stayed relatively flat.

As far as equipment, and lots of hospitals having irrelevant services, I have to suggest that New Jersey is in an entirely different scenario than the rest of the nation. That has to be because New Jersey has been regulated for decades now. Really, 1970 was the first evidence of major regulation in this State. That is not to say that there aren't some instances where if you had to do it over again, you wouldn't do it differently. That is not to say that, but that is certainly true in everything, every institution we know in this country. But it is not the way it is in other states because those controls have been there for some time.

So, I think in areas where you are talking about technology, you may recall that about five years ago, or so, we had quite a fight with the then Commissioner of Health. We ranked something like forty-first or forty-second in the country in terms of new technology, this new item on the block called "CATSCANNERS." I mean, we didn't have any in New Jersey. Now, there are lots of ways to reduce costs, and one is, don't take care of sick people. Then you would reduce all of the costs. Another way is to do it somewhat reasonably.

ASSEMBLYMAN DEVERIN: That is what the insurance companies keep saying, yeah.

MR. SCIBETTA: So, you know, there is a fine balance. I really believe that if we have erred in this State, it has

been very little. We certainly have not erred any more on the over-supply of facilities and technology than we have on the under-supply. What's happening -- as we all know -- is that people don't live where they used to live 10 years ago, 15 years ago. A migration out of the major cities into the suburban and rural areas is taking place. Well, 20 years ago, being a very urbanized State, our hospitals were there to meet the needs of the people in those areas. People are moving out. There is nothing the hospitals did or could have done to constrain that movement out, but they have, again, made certain that they do not build more than is desirable based on the best judgments at the time.

One other factor I hope this State will keep in mind is, when you are talking about the hospital industry in this country, the average hospital in this country is about 50 to 100 beds. The average size hospital in New Jersey, based on our last count, was about 320 beds; 318 I believe is the figure. So, we're talking about looking at little hospitals in this State. A little hospital in the State is about a 200-bed hospital, or a 250-bed hospital, and a tiny hospital is a 150-bed hospital, or less. If you took that hospital and transplanted it anywhere in the country outside of metropolitan New York, Philadelphia, Los Angeles, Chicago, and other major cities, those hospitals would be giants among providers of service.

So, Assemblyman, I apologize if my response to your question about utilization didn't come across in the way I meant it to come across. There is, in fact, before us a considerable debate, to which I am very sensitive, about under-utilization, and we are going to be discussing that question very seriously. Under-utilization, to me, means you don't need something. Less utilization means that things are changing, but it is still needed. I didn't mean to over-complicate a simple issue, but that is what we are dealing

with. We are dealing with less utilization, and probably if we look at the whole scenario throughout the State, we will have very large institutions. The problem the Department has, the problem the hospitals have, and the problem the Boards of Trustees have is, "How much do you really need to make certain that you are providing good care to the public?"

ASSEMBLYMAN DEVERIN: I get concerned, though, when you talk about urban hospitals. In the City of Elizabeth, which I represent, we have three great hospitals. I don't think any of them are in jeopardy. I don't think any of them are under-utilized or less utilized. They seem to be very busy hospitals, and very competent hospitals, with great services. Are there urban hospitals that have other problems?

MR. SCIBETTA: I think that probably most urban hospitals are less utilized, including Elizabeth, less utilized in terms of inpatient services and beds, than they were five or ten years ago.

ASSEMBLYMAN OTLOWSKI: Excuse me, I didn't hear that.

ASSEMBLYMAN DEVERIN: Less than they were.

MR. SCIBETTA: Yeah.

ASSEMBLYMAN DEVERIN: But so are suburban hospitals.

MR. SCIBETTA: Pardon?

ASSEMBLYMAN DEVERIN: So are suburban hospitals.

MR. SCIBETTA: Oh, sure; oh, sure.

ASSEMBLYMAN DEVERIN: If you go to a hospital today for a double hernia operation, you are home in three days. It used to be a month before they would let you out of the place 10 years ago, which was right, in my opinion. You know, you'd see a guy walking out with a cane; he had had a double hernia operation. They used to walk out. But there's no difference in that reasoning, is there?

MR. SCIBETTA: No. I think the other important ingredient is that people tend to want to equate indigent care, the care of the poor that is being provided in our hospitals,

with urban versus rural hospitals, and I would submit that anybody who knows New Jersey would not characterize Bridgeton as an urban setting, or Long Branch as a highly urbanized setting. Those two hospitals are very high providers of indigent care in this State because of the combination of agrarian and urban work habits.

ASSEMBLYMAN COLBURN: Are there any more questions, gentlemen? (negative response) I should have asked this of the Health Department too, but how do we expect the increase of uncompensated care to go over the next few years? Do we think it is going to gradually go up at some particular rate?

MR. SCIBETTA: I don't think it should change significantly, Dr. Colburn, any more or less than it has over the past few years. I think it is a fairly definable number once you get to the number, you know, if, in fact, we have a serious problem in New Jersey, which you folks are closer to than we are, but we don't see it coming. We think the economy in New Jersey is as good as any place in the nation. You know, the automobile industry provided a tremendous problem for the State of Michigan half a dozen years ago until they adjusted to it, so their indigent care costs just absolutely went out of sight.

But, we don't see that happening in this State. We do express great concern over the somewhat arbitrary, capricious activities of the Federal government as far as payment for Medicare patients and social services such as health care and hospital care represent, because we believe that in New Jersey we have been able to address the health care needs of everybody, regardless of their ability to pay, and to provide the absolute best care to everybody, regardless of their ability to pay, because of the decisions that you gentlemen have made over the years. We jealously guard and protect that opportunity. Except for those kinds of vagaries, Dr. Colburn, with Medicare, I don't see any significant change as far as the

numbers of indigent patients are concerned, or uncompensated care in general.

ASSEMBLYMAN COLBURN: Is there anything to be learned from any other states now on this whole subject?

MR. SCIBETTA: Well, I would say on the negative side there is probably more we can learn than on the positive side, because most states are simply not addressing care to the poor. I believe we are going to see some kind of a revolution out there one of these days. On the other hand, there are some states which have done some things to provide somewhat more of a patchwork quilt than some other states. They are primarily pooling as a concept, at least on a temporary basis for a few years, until they see what happens.

ASSEMBLYMAN COLBURN: By our doing a good job of taking care of people who can't afford it, do we attract many people from other places to our State, do you think?

MR. SCIBETTA: It's ironic. I believe the answer to that is no, but what I can't understand is why so many people from the State access care -- well, I can understand it -- but access care in both New York and Philadelphia.

ASSEMBLYMAN COLBURN: That is the ones who can pay, or who are covered.

MR. SCIBETTA: The ones who can pay, or the ones who have insurance coverage. I don't believe we are bringing people into the State because of the health care services at all. I think New York has had a pretty good record of taking care of the poor, as well. Any time you can look at a state and see hospitals that are marginal in their financial status -- marginal being in New Jersey operating margins of, I believe, 1.3%, which is almost at break even, then you can get a pretty good idea that they are probably taking care of their responsibilities as far as taking care of poor people, as well as people who can't necessarily afford to pay their bills.

ASSEMBLYMAN COLBURN: I asked the Health Department, "Are there any economies of regulation that could affect hospital costs?" and I was going to ask you the same thing.

MR. SCIBETTA: Well, I think the combined audit that was mentioned is certainly appropriate. I would suggest regarding the whole question of providing hospitals with flexibility -- which they currently do not have -- to convert existing space, whether it's bed space, office space, or whatever it is, that has been built and pay for and so forth -- to convert them to needs that they may assess without going through, maybe, the same ritual of Certificate of Need requirements as they have in the past. I think that one of the issues we discussed with the Department over the years, that I would like to see us move ahead on, is maybe more in the area of joint efforts on survey results, surveying hospitals for deficiency activities. We believe that some states have a joint survey activity where the Joint Commission on Accreditation of Hospitals, a national organization that accredits all hospitals, be they public or private, profit or nonprofit hospitals -- that they, by definition, accredit or survey hospitals routinely. In fact, without that, Medicare won't participate, and so forth.

We would like to see a closer integration of those activities, if for no other reason than it is a considerable inconvenience to hospitals to be interrupted from service by people going through and checking various elements. Our position has been that if there are areas where the Department of Health must do different things than what the Joint Commission does, we should define what those things are. They may spend more time looking at the food service activities to make sure that the climate is right, and that sort of thing, or some other particular aspects of health and safety to the public. But, we ought to try to see what we can take out of the Department's requirements that is already being done by the

Joint Commission, and only do those things that are absolutely essential, and see if we can get the Department and the hospitals to agree that that makes some sense. It is a joint effort, and I am not suggesting that this is only a one-way street with the Department. It's a pretty massive undertaking, but I think it deserves some attention.

ASSEMBLYMAN COLBURN: Thank you. No more questions?

ASSEMBLYMAN OTLOWSKI: Doctor, I would just like to make this comment. Frankly, from my own observation, I think the hospitals in the urban setting are doing a tremendous job. As a matter of fact, they are the refuge of the poor in many, many instances. They are doing an outstanding job. I have, you know, no criticism of that.

The only thing I would like to point out, and I think we have to be realistic about it-- You talk about the economy in New Jersey being dynamic and moving ahead, and I have no argument with that. But I think what is happening, or what has happened is, the day of the heavy industry, of course, in New Jersey is a thing of the past. I think we got out of the depth of that transition when all the heavy industries left New Jersey, and left the cities. Of course, they staggered the cities, and as a result of that, the cities are now slowly making a comeback with the change of the industrial complexion that is taking place in the cities.

I want to point this out, and I am pointing this out for the record: I think the record should show that if you are going to be cutting back on Federal Medicare and Medicaid, somebody is going to have to pick up that tab. The first place that will be looked at for this pickup, obviously, will be the State. So, when I was asking about costs to the State, I just want everybody to start thinking about the fact that we are going to have to spend more money on the State level. Every cutback on the Federal level is either going to be picked up by the State or it is going to be picked up by the system that we have here, by the property owners.

So, I just want the record to show that I think the hospitals are doing an outstanding job, particularly in the urban areas because, as I said, they are the refuge for the poor, and they still stand there as that refuge.

The other thing I think you talked about, of course, was an indictment of our whole society, and that is the fact that the doctor isn't safe in his own office; the doctor isn't safe on the street at night. You know, the doctor is no different than the little old lady who isn't safe on the street. But, that is something again, of course, that is an indictment of our whole society, and it needs-- Certainly, it is not the business of this hearing, but that is something that needs, you know, real intensive addressing.

I just wanted to point out that neither the medical profession nor the hospitals, as such, can cope with all of the social problems we have, or the dynamic changes that are taking place, for example, even in New Jersey. Maybe out of this hearing I will have a better understanding of the empty bed.

Thank you very much.

MR. SCIBETTA: Thank you, Assemblyman. Mr. Chairman, may I make just one final point? In the area of economic health in the State of New Jersey, the hospital industry represents a $4 billion industry. It is the third largest industry in the State. It is no mean contributor to the continued viability and strength of the State of New Jersey.

Mr. Otlowski, I want to assure you that in these turbulent and changing times, that any praise and recognition that hospitals get is very much appreciated. We will share those comments. Thank you very much.

ASSEMBLYMAN COLBURN: Thanks, gentleman. Mr. Lloyd, from Blue Cross/Blue Shield?

R I C H A R D W. L L O Y D: Mr. Chairman, members of the Committee, my name is Richard Lloyd. I am Manager of Public Relations for Blue Cross and Blue Shield of New Jersey. I want to thank you for the opportunity to testify today.

Assuring that the uninsured poor have access to quality health care is a principle that we at Blue Cross and Blue Shield of New Jersey heartily endorse. Since the inception of the DRG system, payers have shared in the cost of uncompensated care. These payments have guaranteed the poor access to quality medical care, while also providing financial solvency for the hospitals of this State.

Because of this, we at Blue Cross and Blue Shield are extremely concerned as to what effect the absence of the current Federal waiver of Medicare regulations will have on New Jersey's prospective reimbursement system.

Since the inception of the DRG system, Medicare and Medicaid have participated in financing uncompensated care. It now appears that Medicare and Medicaid may withdraw from New Jersey's reimbursement system.

If this occurs, the most critical issue facing the system will be how to deal with the shortfall created by the absence of Medicare or Medicaid contributions toward uncompensated care. We believe it would be a mistake to precipitously shift these governmental liabilities onto the private sector. It is our estimate that if such a shift were to take place, private payer liability for uncompensated care would rise almost $140 million. Having to be burdened with an increase of this magnitude would inevitably result in significantly higher rates for all.

While the financial impact of such an increase would be felt by all, it would have its most detrimental impact on those individuals who purchase their own health insurance. The effect of additional increases may eventually lead some individuals to forego the purchase of health insurance entirely. Lacking health insurance, they may be unable to pay for the cost of unexpected medical care, thereby contributing to the uncompensated care problem.

The majority of people in the State of New Jersey receive their health insurance through their employer. Business in New Jersey has become increasingly concerned with how to control the cost of health care. They have implemented numerous cost containment programs aimed at reducing their health care costs. The imposition of tens of millions of dollars in additional liability can only be viewed as a severe setback to these efforts. Businesses thinking of expanding or relocating in New Jersey may well reconsider any decision in view of the changed environment.

The withdrawal of Medicare and Medicaid from the State DRG system poses a serious problem. We at Blue Cross and Blue Shield do not believe that there are any simple answers as to how to address this anticipated uncompensated care shortfall, but we believe it would be a serious mistake to ask the remaining payers in the system to wholly absorb the burden of Medicare and Medicaid's withdrawal. It is for this reason that it is incumbent upon all parties to seriously look at the issue and examine various approaches, in order to assure that we reach the most equitable solution. Any decision on this issue should only come about after careful deliberation.

We welcome the opportunity to work closely with the Legislature, the members of this Committee, the Department of Health, the New Jersey Hospital Association, and any other interested parties in crafting a fair solution to financing indigent care. By working together we are confident that we can achieve a system that will provide cost-effective quality health care for all the citizens of New Jersey.

ASSEMBLYMAN COLBURN: Thank you. Any questions? Mr. Deverin?

ASSEMBLYMAN DEVERIN: Mr. Lloyd, I was under the impression that we lost the waiver because of $85 million. You said $140 million.

MR. LLOYD: The estimate I have received from our financial people is that there would be about $140 million in total uncompensated care costs in 1986.

ASSEMBLYMAN DEVERIN: Dr. Coye, is that-- The figure I got I think I got from your department, about $85 million.

DEPUTY COMMISSIONER COYE (speaking from audience; not near microphone): Yes, that would now be-- I believe Mr. Russo gave the number. I would suggest that the Medicare shortfall would be $90 million. The Medicaid shortfall, assuming no increase in another pool (indiscernible) of coverage, would be an additional $20 million. That would be $110 million. I cannot explain the difference between that number and $140 million.

ASSEMBLYMAN DEVERIN: Give or take a couple of million.

DEPUTY COMMISSIONER COYE: Well, it is kind of significant.

MR. LLOYD: Obviously we can examine it, but the $110 million is a significant number.

ASSEMBLYMAN DEVERIN: I was just curious.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No, thank you.

ASSEMBLYMAN COLBURN: Do you have any idea what this would cost an average family of four on their insurance premium?

MR. LLOYD: At this time, we don't, Doctor. We are assuming that in that figure of $140 million, Blue Cross and Blue Shield would be picking up about half of that. I do not know specifically what--

ASSEMBLYMAN COLBURN: I just wondered what it would do to the average person's premium if, say, the private people took up all that slack.

MR. LLOYD: I am not exactly-- I think we could probably have our actuaries make a calculation on that.

ASSEMBLYMAN COLBURN: I think we ought to try to get some general idea.

MR. LLOYD: Yeah. I think that is information that could be developed. It certainly would have to lead to higher rates on one level or another.

ASSEMBLYMAN COLBURN: Oh, yeah.

ASSEMBLYMAN DEVERIN: Would it affect the employer?

MR. LLOYD: I think the employer would be the one most affected.

ASSEMBLYMAN DEVERIN: But isn't that done on a--

MR. LLOYD: It would be experience--

ASSEMBLYMAN DEVERIN: Is it an experience contract?

MR. LLOYD: Yeah, but each time one of the subscribers, one of the people covered under an employer's contract went in, the rates would go up based on the stay in the hospital. Since the bulk of our subscribers are receiving health insurance through their employer, I would estimate the bulk of the increase would be felt by employers.

ASSEMBLYMAN COLBURN: Do you have any idea how many subscribers might be lost every time there is a rate increase, or if there was one of large proportions? Is it like trolley cars that lose passengers?

MR. LLOYD: Well, we're in for a rate increase right now with the Department of Insurance, so we might be able to tell you a little better later on the type of-- I think in general, though, people realize the importance of health insurance, and they do come up-- You know, once they have decided to make that initial investment in direct-pay health insurance, they do keep it. There may be individuals who forego, let's say, Major Medical, or who might cut back on the coverages. I think it may cause some people to tend not to buy it who may have been considering buying it in the future.

ASSEMBLYMAN COLBURN: Okay. I guess that is about all the questions we have. Thank you very much.

MR. LLOYD: Okay, thank you.

ASSEMBLYMAN COLBURN: Mr. Fishman, from the Bergen Pines County Hospital?

L E O N A R D F I S H M A N: Thank you, Mr. Chairman. Good afternoon. My name is Leonard Fishman. I am a member of the law firm of Cohen, Shapiro, Polisher, Shiekman and Cohen. We are Rate Counsel to Bergen Pines County Hospital located in Paramus, New Jersey.

Assemblyman Otlowski, you can see from the length of our name that I am one of those neighborhood lawyer philosophers who couldn't make it on my own, so I have thrown in with a large law firm. But I will do a little philosophizing this afternoon. I appear before the Committee this afternoon on a narrow point, but one of great importance to the hospital I represent.

The New Jersey Hospital Association has circulated a proposal to establish a "New Jersey Uncompensated Care Assistance Trust Fund." This proposal has already been described, and there is no need for repetition except to note that the Trust Fund would reimburse the bad debts and charity care incurred by all hospitals covered by the Fund.

Our objection to the proposal is that it defines "hospitals" to mean "all non-governmental acute care hospitals." This definition would exclude Bergen Pines County Hospital, even though Bergen Pines is a part of the Chapter 83 DRG-based hospital--

ASSEMBLYMAN DEVERIN: Excuse me. Would it exclude you from the pool, or would it exclude you from collecting from the pool?

MR. FISHMAN: Well, I believe it would exclude us from both, Assemblyman, even though we are part of the Chapter 83 rate reimbursement setting system, even though we now receive reimbursement for uncompensated care under that system, and even though Bergen Pines is an essential component of the acute health care delivery system in Bergen County. Just very briefly for your information, Bergen Pines is a County-owned facility. It has 1,233 beds, and offers both acute care and

long-term care. At issue here are the 422 acute care beds, which in most respects are like other hospitals throughout the State of New Jersey, except this happens to be a County-operated hospital.

Bergen Pines entered the DRG reimbrusement system in 1982 and, as I mentioned, since that time, has received compensation for uncompensated care, as other acute care hospitals in the State have.

The reason for Bergen Pines' omission from the Hospital Association's proposal, frankly, is not clear. It may have been an oversight. It's possible, also, that the intention was to exclude non-acute care governmental hospitals, because, after all, that is the more typical kind of governmental institution, or it may have been intended to exclude governmental hospitals that had only very severely limited acute care services. If that is the case, then the exclusion was drafted too broadly and needs to be narrowed.

It is also possible, however, that the drafters felt the cost of uncompensated care at governmental hospitals should be borne by the sponsoring governmental authority. But that reasoning really does not apply to Bergen Pines County Hospital, for the reasons that I will give you very briefly:

First of all, because Bergen Pines is, as I mentioned, essentially a conventional acute care hospital, if uncompensated care were not rendered there, it would simply be shifted to other acute care hospitals in Bergen County, and so would be covered by the Trust Fund. It is important to remember, as I have already said, that Bergen Pines is an integral part of the acute care delivery system in Bergen County. It is also, one might say, a magnet for indigents in the County. The 1982 figures of uncompensated care in Bergen County bear that out. Of $17.5 million of uncompensated care County-wide, $8 million, or 45%, was delivered at Bergen Pines County Hospital. So, if Bergen Pines County Hospital did not

exist, as I have said, those patients would simply find their care at other Bergen County hospitals, and that care would be reimbursed through the Hospital Association's proposal, or the Department of Health's proposal, or whatever uncompensated reserve pool the Legislature ultimately produces. The fact that uncompensated care happens to be concentrated at a County facility is no reason to exclude it.

Second, I just want to remind the Committee of the legislative history of Senate Bill 446, which was the legislation that gave us the prospective-based reimbursement system and, also, represented a major departure in the way that uncompensated care was delivered. One of the two major goals of that legislation was to reimburse hospitals for their uncompensated care, and that objective was accomplished by providing that among the financial elements that went into a hospital's reimbursement rate were bad debt and charity care. I know that two of the Assemblymen sitting on the Committee were in the Legislature when Senate Bill 446, really a historic piece of legislation that had national implications, was drafted. The Legislature back then dealt with the issue, what is a county's responsibility for acute care delivered to indigents within that county? The Legislature, very forthrightly, acknowledged that under the system that S-446 gives us, uncompensated care is meant to be distributed across all payers statewide. It is not meant to be concentrated within a county on a county-by-county basis.

I want to quote to you very briefly the Senate Committee statement concerning that bill because there was a proposal that said, "Look, counties are already supporting uncompensated care within their borders by making grants to hospitals. Let's put in the bill a provision that says a county must maintain the support that it was contributing prior to the time this bill was implemented." And the Committee rejected that suggestion. Here is what the Committee said:

"We decided not to adopt a provision requiring counties to maintain existing levels of payments to hospitals for care of indigents. This provision was proposed because of the assumption that counties will withdraw payments for indigent care once the cost of indigent care is spread among payers through S-446. Committee decision was based on the judgment that such provision would, in effect, penalize certain counties for being generous in their payments."

Now, what the Committee was saying was: If you implement that provision, the counties that have historically been generous are going to be frozen into that level of payment, and the ones that have not been generous are going to be rewarded for that because the system is going to pick up their shortfall.

What I would suggest is that in the legislation that this Committee is now considering, the same approach be taken. Let's not penalize Bergen Pines County Hospital or Bergen County -- to paraphrase the Senate Committee -- by excluding it from the uncompensated care pool simply because that County has historically been generous in providing acute care for patients within its borders.

Every county in the State reduced or eliminated its contributions to uncompensated care after Senate Bill 446 was implemented. Bergen County should not be treated differently simply because it happens to operate an acute care hospital.

That is really the thrust of my point. We would ask this Committee to assure that Bergen Pines is placed on the same footing as every other acute care hospital in the State, and that it be included in the Uncompensated Care Assistance Trust Fund, or any similar uncompensated care pool.

I want to thank the Committee for this opportunity to appear, and also to commend the Committee for grappling with this problem now when there can be some calm reflection about the issue of uncompensated care. I know that if the Medicare

waiver were to end without a mechanism being in place, you would need a much larger room probably to contain the crowd, and that would not be the most desirable atmosphere in which to fashion a reasonable solution to the problem.

Thank you very much.

ASSEMBLYMAN COLBURN: Thank you. Any questions? Mr. Deverin?

ASSEMBLYMAN DEVERIN: I agree with what you're saying. I remember -- in fact, I was on that Committee -- very clearly that part of the county compensation, where some counties were given $100,000 for three or four hospitals, and some were given $700,000. So, as far as I am concerned, that statement is true. We probably will, and should look after Bergen Pines.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: Mr. Chairman, I was just going to suggest that he submit a simple memorandum to you, as the Chairman, pointing out how this can be corrected by the policy of the law, so that it will become a fixed policy, and we will be able to correct what seems to be a grave injustice here to Bergen County.

ASSEMBLYMAN COLBURN: I think I just received information a little while ago that perhaps they are now included. Is that your understanding, Craig?

C R A I G B E C K E R (speaking from audience; not near microphone): We have been working obviously with the Department of Health, and this was one of the issues that came up. Both Bergen Pines and Jersey City Medical Center were included. That language has been changed. It was changed, I guess it was approximately a month or so ago. We did communicate that to Tom Casey, the Executive Director of Bergen Pines.

ASSEMBLYMAN COLBURN: Thanks.

MR. FISHMAN: That's quick action.

ASSEMBLYMAN COLBURN: Yeah, that's pretty good.

ASSEMBLYMAN DEVERIN: People say we don't work fast.

ASSEMBLYMAN OTLOWSKI: They knew you were coming.

ASSEMBLYMAN COLBURN: I wanted to ask you something. Let's say that a hospital provides for 20 indigent people, and their per diem rate is a lot higher than another hospital's. They are going to need more money for those 20 people than some other hospital would need for those indigent patients. How do we address the difference in costs between hospitals over the State in this pool? Do you have any suggestions about that?

MR. FISHMAN: Well, as I understand the Hospital Association's proposal, that is to be dealt with by using a flat rate charge for each hospital, which the hospital will then pass on to the payers. In other words, there is not going to be that tremendous variation in the markup factor, depending upon how much uncompensated care is rendered that specific institution. I don't want to--

ASSEMBLYMAN COLBURN: How about the cost for service? Does that address that -- the difference in costs for service, or just the difference in number of indigents in a hospital?

MR. FISHMAN: I don't think it would make a difference in terms of cost per service. If the hospital were adding a uniform markup for each patient, whatever category that patient falls into, and then the hospital received reimbursement through the Uncompensated Care Trust Fund, as I said, not with respect to the specific level of uncompensated care rendered at that hospital, but a uniform amount per patient, I don't think that problem would arise. I think the Hospital Association's proposed legislation-- I have looked at it. It's that brief four-page proposal.

ASSEMBLYMAN COLBURN: I don't think the Committee has really seen anybody's proposed legislation yet. That really hasn't come to us, I don't think.

MR. FISHMAN: I know from listening to the Department of Health and having read their resource papers that their

approach is intended to do the same thing; namely, to not penalize hospitals that render a great deal of uncompensated care by causing a high markup factor.

ASSEMBLYMAN COLBURN: Ms. Grant, do you want to make any comment on that?

MS. GRANT: Your question is whether a higher cost to a hospital would disproportionately either pay into or take out of--

ASSEMBLYMAN COLBURN: Yes.

MS. GRANT: No, the pool does not address that issue per se. The entire rate-setting system has strengths built into it which at some level of cost would begin to disadvantage a hospital if its costs were too high. That is taken care of in other parts of our prospective rate-setting system when the entire cost picture is looked at for a hospital. But the pooling concept per se will say that every hospital -- theoretically every hospital -- will add on the same percentage to the rate. The percentage is calculated in order to generate the total amount of money needed, given the varying costs of the varying hospitals.

ASSEMBLYMAN COLBURN: Okay, thank you. Thank you very much, Mr. Fishman. We appreciate it.

MR. FISHMAN: Thank you, Mr. Chairman and members of the Committee.

ASSEMBLYMAN COLBURN: I am going to ask Reverend Gregory Brown to step up here. Reverend Brown? (no response) I guess he might not be here. Going once, twice -- Reverend Brown? (no response) Dr. Primich -- last but not least.

F R A N K J. P R I M I C H, M.D.: Dr. Colburn, members of the Committee, interested parties, and innocent bystanders: Mr. Scibetta was concerned whether he and his two bodyguards would be adequate competition for the two lovely ladies from the Department of Health. I am here alone as a practicing physician, and I think I can supply as much information as all five of those people.

I do come before you today in two capacities. First, as an individual physician concerned about increasing impediments to my delivery of high quality medical care, equally concerned regarding my patients' access to that care, and disturbed by the chaotic restructuring of the hospital industry in response to ill-conceived intrusionary governmental regulations.

Also, as one who was instrumental in formulating many of the Medical Society of New Jersey's policies on this issue, I have been authorized to field any questions regarding MSNJ's position.

Please accept what I am about to say as my personal observations and recommendations.

As the severest critic of DRGs, I have written extensively on the subject, lectured across the country, and testified on numerous occasions, here and in Washington, to no apparent avail. My highly accurate common sense projections of chaotic consequences are slowly, but surely, coming to pass.

My characterization of DRGs as illogical, impersonal, and all too often inhumane has been substantiated by the growing awareness that patients are being discharged from hospitals "quicker and sicker."

Belated concern about quality of care gives promise of even more misspending of health care dollars on poorly conceived remedies for that problem.

New Jersey was to have been the proving ground for DRGs. At this late stage, there has still been no definite impartial evaluation of this ongoing "experiment." The Department of Health continues to issue unsubstantiated reports of success, while we critics can muster little more than anecdotal evidence of its failure.

Practicing physicians are well aware of the growing compromise of high quality care. When the huge regulatory costs are considered, the program can be shown to have failed

in its primary mission of cost control. As bad as New Jersey's DRGs are, the Federal version is, as predicted, worse.

Whether due to State pride or stupidity, New Jersey's endorsement of DRGs was highly influential in their introduction for use by Federal Medicare. That fatal error has now returned to haunt us.

The impending loss of the Medicare waiver is what brings us here today. This public hearing is presumably designed to elicit suggestions on coping with the reactivation of the "uncompensated care" problem.

The first time around, practicing physicians, those most closely involved in the provision of that care, were all but ignored before and after the fact. It is hoped that with a real doctor chairing this Committee, the situation may improve.

ASSEMBLYMAN COLBURN: I didn't ask him to say that. (laughter)

DR. PRIMICH: The entire cost containment issue must be reevaluated. Rather than enumerate the many indirect sources of escalating health care costs, let me go directly to the root cause.

The government, at all levels, has created the impression, or succumbed to the concept that health care is a "right." This is open to philosophical debate, but for the present it is often stated as an absolute fact. Purely and simply, the government has promised more than it was possible to provide, even in the era of massive deficit spending.

Buying votes through extravagant promises has a price that must be paid. Making scapegoats of health care providers is a deceitful cop-out. Adding a little integrity to the discussion would greatly help avoiding further misdirection on the part of those who propose to bring some sort of order out of this growing confusion.

Taxing tobacco and booze has been suggested, under the guise of penalizing those who are imprudent regarding their life styles. It sounds pretty much to me like discrimination.

If that argument is valid, why not include drug addicts. Since we're unable to tax the source of their "uncontrolled" substance, we might consider levying a retroactive tax on the users to pay for their medical emergencies and attempted rehabilitations. Perhaps we should further extend the idea to include the likes of skiers, mountain climbers, and racing car drivers, since they are all accident prone. Better still, we could levy a dollar a pound a year tax on any person judged to be overweight. We could tax basketball players by the inch, since we all know that "the bigger they are, the harder they fall."

If what I am suggesting sounds facetious, it is intentional. My purpose is to point out the irrational and discriminatory nature of such proposals. The unfairest solution by far is the current, and now proposed, approach of adding a surcharge to the bills of those who are already paying too much for hospital care, in order to fund indigent care.

When Public Law 1978, Chapter 83, was passed, "uncompensated costs" were estimated at $100 million a year. Five years later that figure was approximately $250 million. By now it must be close to $300 million.

After years of rising taxes, New Jersey finally came up with a surplus. Returning the money to the taxpayers was unthinkable. The old-fashioned idea of saving it for a rainy day never occurred to anyone. In the rush to distribute the largess, a portion fortunately was allocated to the new category of "medically needy." Adding some more to that start might help to repair the holes in the safety net.

In summary, my suggestions are that we:

1. Honestly evaluate the expected costs of indigent health care;

2. Truthfully state the restrictions inherent in a low budget; and,

3. Openly propose higher taxes to support fuller services.

If your constituents are unwilling to fund such additional costs, then my recommendation is that we consider a truly two-class system. Contrary to the protests of the egalitarians, that would be a distinct improvement, since we now operate in a three-class system, composed of the rich, the poor, and the rest of us.

Thank you.

ASSEMBLYMAN COLBURN: Thank you. Are there any questions, gentlemen?

ASSEMBLYMAN DEVERIN: Oh, no, not me. (laughter) You're pretty good, Doctor. I'm not going to ask you anything.

ASSEMBLYMAN COLBURN: Mr. Otlowski?

ASSEMBLYMAN OTLOWSKI: No. I'm impressed with the Doctor as a great writer.

ASSEMBLYMAN COLBURN: You then agree with increasing the number -- rather increasing the Medicaid Program by $250,000. Did I get that from what you said, the Medically Needy--

DR. PRIMICH: Essentially, the whole point-- Incidentally, that secondary thing-- I am the only one listed on the program without any association. It was just out of deference to Dr. Ralph Fioretti, who is President of the Medical Society. I thought he would testify, but he is out of town. You have a letter which confirms that their position and mine is that if the government, the people, whatever we want to categorize it as, is responsible for everyone's health care, including indigents, let the government, which quite obviously is the people, pay for it, but don't selectively decide that you are going to catch whoever is out of step this week, whether it is the cigarette smoker, or the lush, or whoever else happens to be in some state of poor social standing, to have them pay for it.

If it is a free country, and if it is majority rule, and if the majority of people say, "We are going to pay for

this," then the majority of people, and everyone, should pay taxes to fund this. As I say, it is so utterly wrong that when you have people who are sick, particularly everybody worries about the indigent, the poor. I am duly concerned about them, but I am more concerned about the poor devils who have struggled all their lives, who have a few bucks, who don't have the wherewithal, don't have insurance, and now they get hit with all of this with our cost shift. Before, after, and in the future, those poor people are always going to be picking up the slack where the Hospital Association wasn't -- or the hospitals individually were not able to pad their proposals enough to come out with a living number.

This crazy idea of negotiation is a major problem that exists, because literally when you negotiate, the rules say that something has to give. A long time ago, I characterized this; I gave an example of how the system might work, and that is that the hospital administrators look over their books with their good accountants, and they come out and they figure, "It is going to cost us 'X' number of dollars. Well, what we are going to submit is 20% more than that. Then we will have a fighting chance because if we give them the 100%, sure as hell we are going to come out losing money."

Now they go to Blue Cross, which was delegated to set the fees that the rest of the people are going to play by. And Blue Cross says, "Oh my goodness, we have to protect our subscribers. Knock off 5%." That's not too bad for the hospital, but now they have to go to the Insurance Commissioner. The Insurance Commissioner says, "Oh my God, I have to protect all the people of New Jersey, you damned thieves." Another 5% gets lopped off. They take the 10% that's left, and the three of them go out to lunch. In other words, this whole thing becomes a swindle.

ASSEMBLYMAN DEVERIN: You mean they padded the budget to begin with?

DR. PRIMICH: Yes, but that's the way everybody seems to do if they are going to negotiate. If you want to be honest and you say--

ASSEMBLYMAN DEVERIN: That is not unique in the hospital business.

DR. PRIMICH: Pardon?

ASSEMBLYMAN DEVERIN: That's not unique in the hospital business. There are a lot of organizations--

DR. PRIMICH: No, of course, but what I am trying to explain is the way that when you get into these projections of costs, how these things-- If anybody makes the sad mistake in this system of trying to be honest, they have to go broke. I've done it.

The question came up with Medicare, Medicaid, and so on, and my own personal policy -- which Mr. Otlowski has become aware of over a period of time, as well as a few others -- is that I very thoroughly oppose government intrusion into any of this. I don't think it is any of their business. They should preserve law and order and a few other things. Certainly where fraud is involved, or any misrepresentation, that is part of their job. But running health care should be left to the doctors. Somewhere along the way I got the wild idea that if you guys weren't going to let us run health care, I was going to come in and try to help you run the government. So I ran for Governor as a Libertarian Party candidate, and it was quite obvious that the people of New Jersey didn't share my high opinion of my potential.

But, the point I am trying to make as far as my own personal thing is concerned, is that I have literally refused, from day one, to accept Medicaid, on the basis of the fact that it was ridiculous the way they structured the payments, although in those days they weren't as far out of whack, but what was coming was obvious to me. What I did was, if a person asked me, "Do you accept Medicaid? I said, "No," and, in most

cases, they went elsewhere. If a patient came to my office and I didn't have any kind of a financial wizard out there screening the patients, the patient came in, my nurse took the basic history, I examined him, took what further history was necessary, went into my consultation room, told him what I thought the diagnosis was, what I felt was the proper treatment for this, and he either paid me or my nurse my normal fee. If and when at that point the patient said, "But I've got Medicaid," I said, "See, I don't accept Medicaid. Now, this is my fee and it is a very reasonable fee. If you can pay it, I'll appreciate it. If you can part of it, I will appreciate that. If you can't pay any of it, don't worry about it. I will never dun you, but I will never bill the Federal government for it." And that was how that part of it went.

With Medicare, there was a option, because that was the one where in order to get doctors to go for this big con game, they promised us, absolutely, that we could balance-bill, which within the past few years has gotten into a pretty scrambled picture as to what will or will not be done. However, on that basis, I absolutely refused to ever send a form to Medicare. I would see the patient, charge him my reasonable fee, give him a receipt, and he would sent in the thing.

However, the mistake I made was that as liability premiums went up, as inflation occurred, as all the rest of these things occurred, my costs kept going up and up and up, and I kept increasing my fees, always a little behind the times, but doing the best I could. However, when a little old lady came in, I would look back, and on my simple little cards that I keep, over in a corner I have a number, which is what I charged. If the patient had paid it, I had a circle around it. If the patient hadn't paid it, there was a minus sign by it. That is my basic bookkeeping system. And, I would look, and I would say, "Well, I charged her 30 bucks last year. What

the hell, she looks kind of in pretty dire straits, I'll make up what I need to catch up on somebody else." Of course, what happened then was, I gave her the receipt -- all right? -- and she sent it into Medicare. Medicare has a big computer down there with nothing more to do than prepare a profile on me. It turns out eventually that I am a cheap doctor. Some clown who can't carry my medical bag charges twice as much as I do, and on a Medicare computer he is entitled to twice as much.

This is among the inequities that are involved in this thing, and there we stand.

ASSEMBLYMAN COLBURN: I must express some sympathy on your problem of the low profile because I share that with you, but that is not exactly the subject of our hearing today. The Medical Society sent us a letter which said: "Since the State and Federal governments have declared health care a human right, the uncompensated care problem should be solved by taxation." That is basically what they said. So I agree that that is what they did say.

Now, is there anything else in here that you can suggest to help us to overcome the problem that we're in? Unfortunately, we can't repeal everything that has happened for the last 20 years or so -- maybe 50.

DR. PRIMICH: The last time I testified at one of these hearings, when I was leaving, some nice lady came up and told me I was the most entertaining one there. If you want a little more entertainment, you can ask me to expand on my two-class system.

ASSEMBLYMAN COLBURN: Well, I have to agree we are already in a several-class system right now, because I know in our office some years ago, when insurance was coming in, I think it was Governor Hughes, or somebody, told us that we shouldn't charge people different amounts based on whether they were covered by insurance or not. And now the payers are paying us different amounts based on what kind of coverage they

have. So, I don't think we want to necessarily get into that. We have some studying to do, you know, of all this information.

DR. PRIMICH: My purpose in raising that question was that usually what happens when one is critical of a bad idea-- The philosophy seems to be, unless you have another idea, we don't want to hear about it.

ASSEMBLYMAN COLBURN: Well, it is a help to have alternatives, I must admit.

DR. PRIMICH: But, as I said, literally it is a fairly simple thing. The only thing that is cutesy about it is that it applies the baseball concept of a National League and an American League.

ASSEMBLYMAN COLBURN: Why don't you give us that in writing, instead of in your testimony.

DR. PRIMICH: I'll write you a letter.

ASSEMBLYMAN COLBURN: Thanks, Dr. Primich.

I want to point out that the purpose of this hearing was to try to get information in advance of the crisis. That is what we are attempting to do, so that toward the end of it we won't get into an absolutely crisis situation, although maybe we will. I have a feeling problems are inclined to be solved about the time they occur, and not much in advance. But at least this was an attempt to do that.

We are going to leave the record open for about 30 days, so if anyone has any more written material to send to us we would appreciate having it, particularly since two of our members haven't been here.

Thanks for attending, and thanks, Dr. Primich.

DR. PRIMICH: Thank you.

(HEARING CONCLUDED)

APPENDIX

PROPOSAL FOR UNCOMPENSATED CARE POOL

QUESTIONS AND ANSWERS CONCERNING THE FINANCING OF UNCOMPENSATED CARE

The following questions and answers should make clear what are the State's existing policies with respect to hospital uncompensated care, what changes in the environment require a response if the State's policies are to be continued, and what kinds of responses are feasible.

1. Q: What is the statutory authority for the payment of hospital uncompensated care; how is it currently administered and by whom?

   A: P.L. 1978, Chapter 83, created an all-payer prospective rate setting system that regulates all short-term general acute care hospitals in New Jersey. The law provided for regulations to be promulgated by the Commissioner on the approval of the Health Care Administration Board (HCAB). It also created the New Jersey Hospital Rate Setting Commission to approve hospital rates upon the recommendation of the Commissioner through the Hospital Reimbursement Program of the Division of Health Planning and Resources Development.

   The law instructs the Commissioner to include the reasonable cost of providing uncompensated care as an allowable cost in the setting of hospital rates. Uncompensated care is defined as the sum of charity care and bad debt, provided adequate recovery procedures are followed. Based on this provision, each year the Hospital Rate Setting Commission approves, for each hospital's rates, a "factor" for the collection of its own hospital-specific approved uncompensated care amount. Each hospital has its own factor with which to "mark-up" its rates to collect reimbursement sufficient to pay for its own uncompensated care . The resulting percent increase in the rates of paying patients varies across hospitals, from 1% to 25%, with an average of 7-8%.

2. Q: Who pays for uncompensated care and how much?

   A: All purchasers of hospital services pay a proportional share of uncompensated care, based on their share of utilization of hospital services. Total state-wide uncompensated care is about $250 million annually.

Medicare pays 40%, or about $100 million; Medicaid 8.5% or $21 million; Blue Cross 20% or $50 million; and all others pay the remaining $79 million.

3. Q: If the system is working, why do we need something new?

A: The system is working but, unless new provisions are made, it may not work for long. Medicare participation is contingent upon savings. That is, Medicare must pay no more under the rates set by New Jersey (rates which include $100 million of uncompensated care in Medicare payments) than it would pay under its own rate setting system, which does not recognize the cost of uncompensated care. When the current "waiver" of Medicare rate setting rules was granted late in 1984, savings of $200 million were projected for the period 1985 through 1987, and performance to date has been consistent with projections. However, during the latter part of 1985, the Federal government enacted sharp and arbitrary reductions in Medicare rates nationally. With these new rates as the basis for comparison, it is not likely that New Jersey will be able to continue to generate savings while paying for uncompensated care. In either case, an amount of uncompensated care will either go unpaid, or be paid by some entity other than Medicare. State law appears to require that shortfalls of uncompensated care be reallocated to other payers.

It should be added that a reduction in Medicare payments is likely to be followed by a reduction in Medicaid payments, and so Medicaid's contribution toward uncompensated care ($21 million annually) is also threatened.

As these reductions in Federal payments occur, a pool will allow for an orderly way to continue collection of monies for uncompensated care as New Jersey goes through the transition from waivered to non-waivered status, or as New Jersey continues the waiver by reducing Medicare's share of uncompensated care .

4. Q: Are cutbacks in Federal reimbursement the only reason for proposing a pool?

A: No. There are other changes in the health care environment which will soon make pooling of uncompensated care essential. At both the national and the State level, we are experiencing a rapid increase in the proportion of patients whose health care costs are paid by a third-party entity that price shops and, if possible, negotiates

reduced hospital rates. Most prominent among these third-party payers are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). These organizations are expected to result in significant savings to the consumer; however, they also represent a potential problem. As they shop for lower prices, it is inevitable that the hospitals least able to compete for their business will be the ones where a significant component of the price is the factor which exists to pay for uncompensated care. Thus, the existing system may put hospitals with high uncompensated care at an unfair competitive disadvantage.

In addition, by avoiding hospitals with high uncompensated care, payers that price shop necessarily pay less than their proportional share of the state-wide burden, leaving a greater share to be paid by the other payers. Thus, the current system may result in an inequity among payers as well as hospitals.

5. Q: How would a pool work and how would it solve these problems of Federal cutbacks and competitive inequity?

A: The following two-hospital example illustrates how the current system works and how the pool would work.

Current System	Hospital A	Hospital B
Cost of paying patients	$10,000	$10,000
% add-on for uncompensated care	5%	9%
Resulting charges	$10,500	$10,900
Uncompensated care needed/charged	$ 500	$ 900

Pooling Approach		
Cost of Paying patients	$10,000	$10,000
% add-on for uncompensated care (at state-wide average)	7%	7%
Resulting charges	$10,700	$10,700
Uncompensated care needed	$ 500	$ 900
Uncompensated care charged	$ 700	$ 700
Amount due to/(from) pool	$ 200	$ (200)

The two hypothetical hospitals have identical costs associated with paying patients. Hospital B, however, has

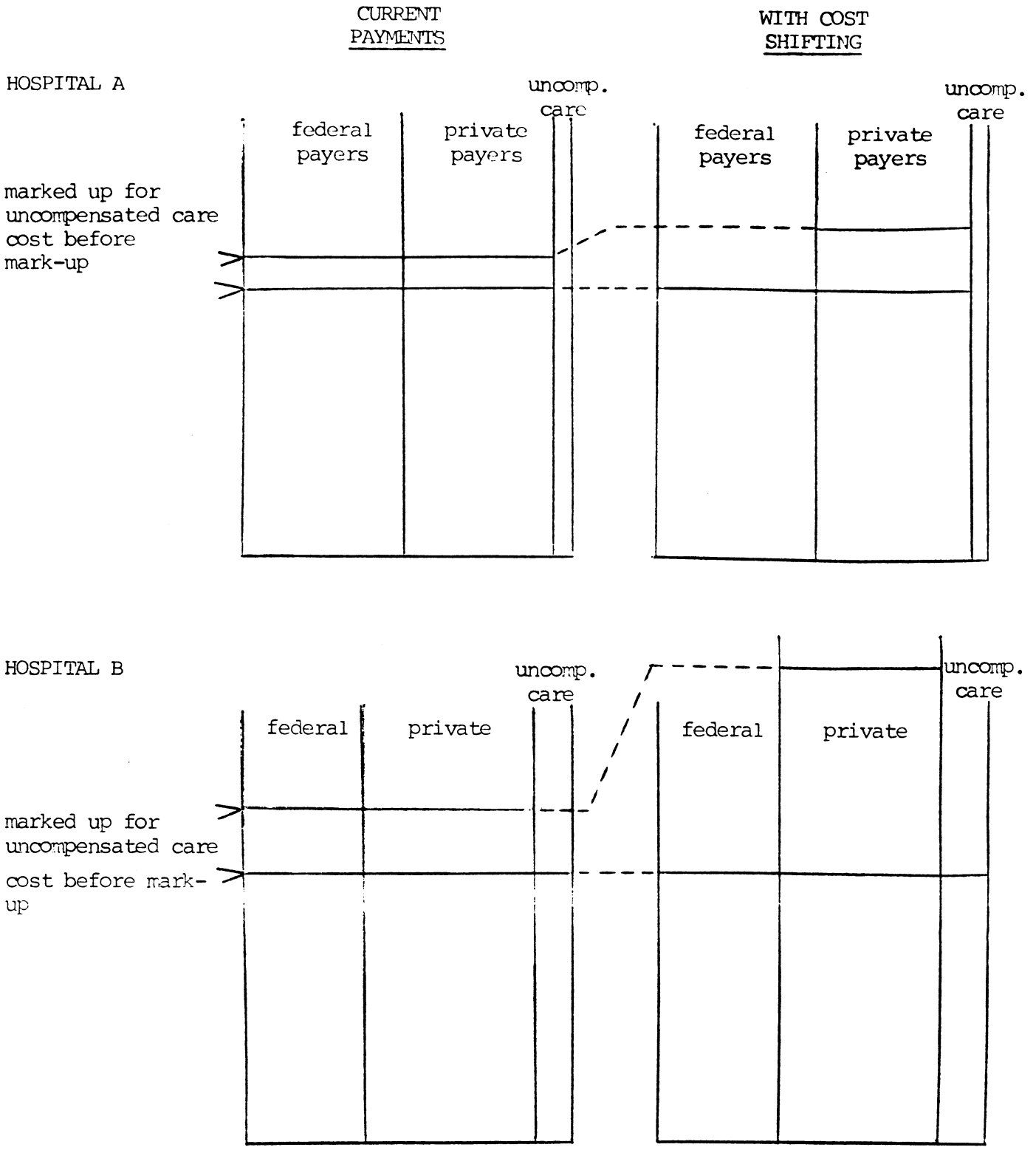
more uncompensated care and so must charge more than Hospital A in order to be reimbursed for the care provided. Therefore, under the existing system, its rates are higher and it suffers a competitive disadvantage.

A pool would require that both hospitals charge the state-wide average percent add-on for uncompensated care. Hospital B still needs more than Hospital A in order to be reimbursed for the uncompensated care it provides, but it now charges the same rate so there is competitive equity. The function of the pool mechanism is to collect, from Hospital A, the excess that it collects by using the state-wide factor and to pay to Hospital B the shortfall it experiences by doing the same. Thus, the pool merely reallocates funds so that all hospitals receive their approved amount for the care they provide while billing the state-wide average add-on.

This example has shown how a pool would solve the problem of competitive inequity. The problem of Federal cutbacks is somewhat related. That is, in the case of small or moderate "shortfalls" in Medicare's contribution toward uncompensated care, the most likely solution is a shifting of the amount of that shortfall to the private payers. However, raising the private payers share of the uncompensated care burden, without a pool in place, would result in a sharp increase in the relative prices and, therefore, the competitive disadvantage of those hospitals already disadvantaged. The following two-hospital example illustrates why this is true.

In this example, Hospital A has relatively little uncompensated care and many privately insured patients to whom it may shift the shortfall if Federal payers pay less for uncompensated care. Therefore, the additional "mark-up" to the rates of private payers is small. Hospital B, however, has high uncompensated care and, as is often the case with such hospitals, relatively few privately insured patients to whom a Federal shortfall may be shifted. As a result, the additional "mark-up" to the rates of the private payers is quite large, further increasing the price differential between Hospitals A and B.

If reductions in Federal payments reach a point where the state-wide shortfall of uncompensated care payments cannot entirely be shifted to the private payers, the pool mechanism provides a means to channel funds from other sources to the appropriate hospitals.


CURRENT PAYMENTS
WITH COST SHIFTING
HOSPITAL A
federal payers
private payers
uncomp. care
federal payers
private payers
uncomp. care
marked up for uncompensated care cost before mark-up
HOSPITAL B
federal
private
uncomp. care
federal
private
uncomp. care
marked up for uncompensated care cost before mark-up

6. Q: Reallocation of payment to private payers has been mentioned as a solution to the potential Federal shortfall. Are there others?

   A: Short-run solutions are limited. Aside from cost-shifting, governmental appropriations are the only means of quickly addressing a shortfall in funding. State appropriations to the pool or to hospitals would reduce the size of the shortfall. County grants to hospitals, which declined sharply after the introduction of the all-payer reimbursement system, could be increased again to offset part of the Federal shortfall.

   There are a number of longer run solutions being considered, but none of them can be implemented within the relevant timeframe.

7. Q: Why should the system continue to pay the "bad debt" portion of uncompensated care? Aren't these individuals able to pay their bills, and aren't we encouraging lax collection efforts?

   A: Patients whose bills become bad debts are not necessarily "dead beats" and, even in the case of those who are, there is reason to believe that most hospitals make all reasonable efforts to collect on the account.

   Many patients in the bad debt category are poor but fail to qualify for charity care only because they fail to provide the hospital with proof of low income. In the absence of such proof, the hospital must handle the account under the assumption that the patient has the ability to pay. After collection efforts fail to produce payment, the accountbecomes a bad debt.

   Other patients who fall into the bad debt category are uninsured, have income above the charity care income limit, and are faced with a hospital bill that may be equal to their annual income. These accounts will likely become bad debts as well, and it is difficult to believe that they could be collected.

   Finally, there are patients who are uninsured or who have deductibles and coinsurance to pay, who can afford to pay, but refuse. In this case, as in the others, the hospital will bill the patient and will attempt to make contact by letter and by telephone. After a specified time period, the account is normally given to a collection agency. The fact that bad debt is reimbursed can have a dampening effect on the vigor with which the collection agency

pursues the patient because the agency is paid only for collected accounts.

The final safeguard is an audit carried out by the Department of Health, which institutes financial penalties if hospitals cannot demonstrate that adequate collection efforts were used. It is believed that this audit needs to be strengthened and so a part of the proposal is for an expanded audit and a high level Advisory Committee to monitor and advise concerning the audit.

8. Q: To what extent are the problems of inner-city hospitals simply a function of their own inefficiency?

   A: This question is repeated regularly but is rarely made specific or clear. The issue may be one of efficiency in provision of care. Unlike the Federal payment system of Medicare, the New Jersey system does not pay hospitals more simply for having an urban location. Therefore, to the extent urban hospitals are living within their reimbursement, they may be considered reasonably efficient in the provision of inpatient care. Outpatient care is a different matter, and there is concern that too often high cost emergency room or specialty clinic settings are used to provide simple routine care. The Department will be taking steps in the near future to try to address this problem.

   Another question, however, is whether urban hospitals employ effective collection efforts, or include cases in their uncompensated care where collection is possible or where a payer (such as Medicaid) could be identified. Given the high volume of non-paying patients, especially ambulatory care patients, in many urban hospitals it is plausible that such a problem could exit. Unfortunately, hard evidence does not exist and assertions about this question are no more than speculation. There is a need both to expand the Department's audit program and to carry out a study of patients receiving uncompensated services to see whether they are insurable and to determine the extent payment could be obtained. The Department is beginning to plan both these activities.

9. Q: Seven years ago, there was no all-payer system and Medicare did not pay for uncompensated care. Why won't this situation simply resolve itself by reverting to the pre-waiver status quo?

   A: First, the pre-waiver status quo was unacceptable. That is why it did not persist? Urban hospitals were increasingly

insolvent and continued access to care for the poor was in serious danger.

Second, some sources of payment that existed in 1979 have reduced their contribution to care for the poor. County grants to hospitals were estimated at nearly $19 million in 1980. Most counties, however, have stopped these grants preferring to let the reimbursement system carry the responsibility. In addition, the Medicaid program, both in New Jersey and nationally, has reduced its coverage of the poverty population. In 1979, Medicaid in New Jersey covered 64% of those below the poverty level. In 1983, it had 8% fewer recipients, in absolute numbers, than in 1979. Changes in eligibility standard account for much of this change, and result in a greater number of poor individuals who are uninsured.

Third, to the extent uncompensated care was covered prior to the all-payer system, it was covered through increased charges to unregulated payers. Today, many private payers and employers have a greater ability to protect against this by selecting hospitals with low uncompensated care costs. This problem, which exists under the existing collection mechanism, would still exist if we reverted to the pre-waiver situation, and would have the same negative effects that we are trying to avoid.

The above discussion outlines the need for a pool and describes how a pool would work. Another question relates to timing. When do we need the pool? The Department feels the pool should be created as soon as possible because in reality we need it now.

Before mid-summer, New Jersey is likely to be facing serious decisions regarding the question of whether to continue the Medicare waiver If a pool is nearing implementation, New Jersey will have more options. Minor shifting of uncompensated care costs to preserve the waiver will be more feasible if there is a pool to equitably collect and allocate the funds. If, instead, New Jersey chooses to terminate the waiver, a pool is essential to prevent serious disruptions in payment for uncompensated care.

For these reasons, it is very important that New Jersey have a reserve pool in place before it becomes necessary to take action regarding the waiver.

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STATEMENT OF LOUIS P. SCIBETTA, F.A.C.H.E.

PRESIDENT, NEW JERSEY HOSPITAL ASSOCIATION

BEFORE THE

NEW JERSEY STATE ASSEMBLY COMMITTEE

ON HEALTH AND HUMAN RESOURCES

Monday, March 24. 1986

I am LOUIS P. SCIBETTA, President of the New Jersey Hospital Association, a not-for-profit organization that represents all New Jersey hospitals and the health care services they provide.

I am pleased to address this public hearing on matters of utmost concern to the state, the hospital industry, and the people who pay for about $4 billion in health care delivered in New Jersey last year. I would like to speak briefly today about costs, care and commitment.

In 1978, in an effort to curb costs and ensure the solvency of hospitals-particulalry those having a high indigent care caseload- the New Jersey Legislature passed a law that gave the Department of Health total control over the hospitals' ability to change (CON) and simultaneously established how hospitals should be paid. For Medicare and Medicaid to participate under the New Jersey law, it was necessary for the federal government to "waive" federal reimbursement regulations.

In 1980, and again in 1985, the Health Care Financing Administration granted a waiver that allowed Medicare participation under New Jersey regulations, rather than federal regulations. The state Department of Health phased in a payment system for acute-care hospitals based on diagnosis rather than length of stay. The DRG

(Diagnosis Related Group) approach was the state's way of implementing a uniform "all-payer" system that applied to anyone paying for hospital care - Blue Cross, private insurers, and the federal government.

In this system all the state's payers contribute to hospitals' indigent care costs by paying a percentage add-on to the prospective rates.

Under this DRG approach to reimbursement, where the amount of payment for treatment is set in advance, the rate of increase of hospital expenditures and length of stay have declined. Now in its fifth year of operating under its own prospective pricing system for both Medicare and non-Medicare patients, New Jersey has set benchmarks for efficiency and cost control, while at the same time meeting its obligation to cover the hospital costs of those who can not or will not pay their bills.

Collectively our 106 hospitals showed an operating income of $43 million in 1984. By comparison, six Philadelphia hospitals alone showed a similar bottom line over the same period. In 1984 New Jersey patients paid $383 less per hospital stay than the same patient would have elsewhere in the nation. New Jersey hospitals rank 48th out of 50 states and the District of Columbia in rate of increase of both expense and revenue per adjusted admission.

But now, we find ourselves approaching a crossroad. Under our waiver agreement with the federal government, New Jersey has to demonstrate that our hospitals' actual

aggregate Medicare payments do not exceed the aggregate payments hospitals would have received under the federal government's own DRG system. To date we have consistently met the federal government's spending limits that allows us to "do our own thing" and do it well.

However, these are unpredictable times in Washington. With talk of federal freezes, Gramm-Rudman, and possible cuts in Medicare reimbursement rates, the types of savings we've guaranteed to the federal government may be impossible to implement without imposing severe financial constraints on the state's hospitals. Because our hospital specific rates have been so low in comparison to the rest of the nation, any cuts on the federal level will hurt us all the more. In short, we run the risk of being penalized for doing a good job.

One possible solution is to drop the federal Medicare waiver and shift the Medicare reimbursement portion of our all-payer system over to national rates. We believe that New Jersey hospitals could survive such a move, but there is one catch.

Under the Medicare waiver, the state's system was able to direct payment differently than under the federal system. This system enabled <u>all</u> hospitals to be reimbursed for all there uncompensated care. Loss of the waiver would then direct payment according to the federal system. This will result in a "different distribution," <u>not a shortfall</u> of about $100 million. This shortfall is a result of the differences between

the two systems.

It has been said that since uncompensated care is not paid for under the federal system, that the $100 million will not be paid. This is not true, because that argument doesn't look at the total Medicare reimbursement system. It is true that the federal system does not pay for uncompensated care, but because New Jersey's costs are so efficient when compared to other state's, the federal system will pay New Jersey hospitals MORE for its operating costs than it does under the current New Jersey system.

Therefore, when all aspects of the federal payment system versus the New Jersey system are considered, New Jersey hospitals would receive more dollars if we were under a total federal reimbursement mechanism. However, because of the recent federal cost-cutting initiatives, such as Gramm-Rudman, there may be a possible shortfall of between $25-40 million. While the shortfall is not nearly as severe as the maldistribution of funds, that maldistribution is nevertheless a problem.

The New Jersey Hospital Association has proposed a solution to that problem that has, to date, won broad-based support not only from our industry, but from the state Department of Health, with whom we are working closely on this issue.

Our plan is to introduce legislation that would create a trust fund solely to cover the cost of uncompensated care. The payer, in the form of an uncompensated care

payment mechanism would be designed to pay for all actual uncompensated care delivered in the state, both inpatient and outpatient. We feel the system would be equitable for all hospitals and not compromise our social commitment to give the best care possible to ALL New Jerseyans, regardless of their ability to pay.

In short, such a fund would function under a separate trust fund located in the Department of Health, regulated by the Hospital Rate Setting Commission and advised by a trustee committee of representatives from various governmental departments and the hospital industry. The fund would be financed by a uniform flat add on to hospitals' rates and charged to all payers.

The mechanics for distribution of funds would be simple. Think of it as a funnel. On one end, all hospitals would pay the fund its flat-rate input monthly. On the other end, those same hospitals are reimbursed regularly for their ACTUAL uncompensated care costs.
A strict auditing process will guarantee equitable distribution of funds.

What will be the cost to the state?

We feel the state has a "social responsibility" to help fund the shortfall and should pick up the Medicaid portion of the $275 million price tag.

What are the benefits of such a system?

(1) The state's reliance on the unpredictable status of

the Medicare Waiver will be lessened, allowing for New Jersey's smooth entry into a national DRG system for Medicare reimbursement, if it so chooses..

(2) Hospitals that cannot otherwise compete with neighboring hospitals because of high uncompensated care case loads will NOT be unfairly penalized because of geographic location or the economic status of their patients;

And

(3) As we have continued to guarantee in the past and will vow for the future, New Jersey's model hospital system will NEVER refuse a patient treatment because of his or her inability to pay the bill.

Our citizens should expect no less from us. New Jersey health care institutions will continue to provide quality care, 24 hours a day, seven days a week ... that access to everyone will not be compromised.

It should be noted in conclusion: While the Hospital Association strongly supports the use of a fund concept to pay for uncompensated care, we do not see this as a precedent for dealing with other fiscal matters such as payment for Graduate Medical Education or Capital costs.

I thank you for your time and consideration of this important matter. I will be glad to answer any questions you may have.

MEDICAL SOCIETY OF NEW JERSEY

EXECUTIVE OFFICES ☐ TWO PRINCESS ROAD, LAWRENCEVILLE, NEW JERSEY 08648 ☐ TELEPHONE 609-896-1766

March 4, 1986

Honorable Harold L. Colburn, Jr.
223 High Street
Mt. Holly, N.J. 08060

Dear Assemblyman Colburn:

Because of prior conflicting engagements we will be unable to attend the Health & Human Resources hearing on March 24th regarding indigent costs.

The Medical Society of New Jersey has given very careful consideration to this issue for over ten years. We have presented our views, both orally, and in writing, to the Governor, the Legislature, and the Health Department.

State and Federal governments have declared health care a right. Since it presents a universal societal issue, payment for indigent patients should be met by the government from tax revenues. The funds in question should derive from the general treasury. They should not be raised by increased charges to the "paying" patients in our health care system since they form an insufficient base to sustain the financial obligations of society as a whole.

I hope you will find these comments helpful and I sincerely appreciate this opportunity to present our views.

Respectfully submitted,

Ralph J. Fioretti, M.D.
President

RJF:j

bcc:David Price, Assembly Committee Aide

16X

New Jersey
Business & Industry
Association

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

April 18, 1986

Hon. Harold L. Colburn, Jr., M.D.
223 High Street
Mt. Holly, NJ 08606

Dear Harold:

Please review the enclosed statement by New Jersey Business and Industry Association in connection with the recent public hearing held by the Assembly Health and Human Resources Committee on the subject of "Financing Hospital Care for the Medically Indigent."

Some of the testimony indicated that one way to resolve the loss of federal funds for indigent medical care would be by having business absorb this shortfall through an increase in the DRG rate. We feel that hospital care for the medically indigent is a social problem that should be supported through the General Fund rather than one specific revenue source.

Accordingly, we are compelled to submit a statement for the record expressing the concerns of our 11,000 members.

Sincerely,

Joseph E. Gonzalez
Senior Vice President

so
Enclosure
p.c. John Kohler
David Price

17X

New Jersey
Business & Industry
Association

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

STATEMENT

OF THE

NEW JERSEY BUSINESS AND INDUSTRY ASSOCIATION

TO THE

NEW JERSEY ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

PUBLIC HEARING

ON

FINANCING HOSPITAL CARE FOR THE MEDICALLY INDIGENT

April, 1986

18X

New Jersey Business and Industry Association, the largest Association of employers in the State, takes this opportunity to convey the concerns of the business community for the pending withdrawal of the federal "waiver" under which New Jersey hospitals are reimbursed for providing hospital care for the indigent. While we support, in general, many of proposed solutions expressed at the Public Hearing, held on March 24, 1986, by several of the concerned interest groups that testified: We can not agree in total, with all of the recommendations for resolving the pending crisis.

We are fully aware of the fact that as a result of the withdrawal of federal funds for the reimbursement of hospital indigent care there will be a shortfall in required revenue. On behalf of New Jersey employers we are prepared to suggest, for your consideration, a possible solution to this dilemma.

Historical Prospective

It is appropriate at the outset of this statement to review some of the circumstances that were created when the present system of hospital rate setting took effect. Prior to 1980, medical care for the indigent was recognized as a social responsibility of the taxpaying public and hospitals were reimbursed for uncompensated costs by municipal and county government with revenue raised from property taxes. When the Diagnostic Related Group (DRG) system of charging for hospital services was enacted in 1980 a large segment of uncompensated hospital care incurred by the indigent was transferred to the insured public. Uncompensated hospital care was designated a factor in calculating the DRG reimbursement rate. Inasmuch as the vast majority of insured New Jersey citizens receive their health care insurance from their employers group health insurance program, employers were assessed this additional cost. The business community reluctantly accepted this civic responsibility and implemented a number of cost containment programs to control the escalating cost of group health insurance programs.

Proposals for Funding the Shortfall

New Jersey Business and Industry Association supports both the "pooling" and "Trust Fund" concepts as proposed by the New Jersey Department of Health and the New Jersey Hospital Association. These concepts, we believe, are the first steps in resolving the uncompensated indigent hospital care dilemma. It is at this point that we part company with the proponents of the pooling and trust fund concepts.

The suggested mechanism for providing additional revenue to the trust fund as a result of a reduction in federal funds is to further increase the DRG factor. This places an additional burden on the insured and primarily the employer. We do not believe that the fund should be financed by a uniform flat add-on to a hospital's rates that is charged to all payors. This concept will significantly further increase an employer's current premium costs. Reimbursing hospitals for indigent care is a social responsibility and should be supported by all taxpayers from general revenues and not solely by the sick, the poor or employers.

New Jersey Business and Industry Association believes that each taxpayer should be required to support the indigent similar to the manner in which welfare funds are provided to individuals or families in need. We believe that it would be a serious error to impose this additional cost primarily on the business community. The concept is counterproductive to an employer's cost-containment efforts. It places New Jersey employers at a competitive disadvantage with employers in other states.

Therefore, we propose that the required revenue to continue funding hospital care for the indigent should come from State General Revenue Funds. Funding for this social responsibility is the responsibility of all of the citizens of the State and not any one segment.

Health Insurance for the Unemployed

At a Public Hearing of this Committee several years ago, New Jersey Business and Industry Association provided testimony directed at resolving the lack of health insurance for the unemployed. At that hearing a number of individuals testified that health insurance coverage was available for the unemployed, but that it was unaffordable by individuals who are unemployed.

We suggested that all insurance carriers, doing business in New Jersey, should be required to offer all workers in the State health insurance coverage that would become effective in the event of unemployment. We believe that this new form of health insurance would be affordable because the premium would be paid during periods of employment and waived during unemployment. This coverage could be made available as a separate policy or as a surcharge on an existing policy. This premium would be held in trust by the carrier for the specific use of the unemployed.

Conclusion

New Jersey Business and Industry Association urges that the Assembly Health and Human Resources Committee seriously consider our suggestions for resolving the pending reduction or elimination of federal funds for hospital care for the indigent.

Regional Health Planning Council
Eight Park Place, Newark, New Jersey 07102 • (201) 622-3280

Dennis G. Cherot
President

Martin L. Parker
Executive Director

March 17, 1986

Mr. Joseph Colburn, Jr.
Chairman
Assembly Health & Human Resources
Committee
CN 068
State House Annex
Trenton, NJ 08625

Dear Assemblyman Colburn:

I would like to thank you and your committee members for the opportunity to present comments on the very critical provision of hospital-based indigent care.

I am writing these comments as president of the Regional Health Planning Council, the Health Systems Agency for Essex, Morris, Sussex, Union and Warren Counties. As the Health Systems Agency, the Council is mandated to ensure that high quality health services at a reasonable cost are available and accessible to residents of our planning region. With this mandate, we are very much concerned about the provision of indigent care.

The development of New Jersey's all-payor DRG system (with its inclusion of uncompensated care to the indigent as an expense to be paid by all users of the hospital) took a major step in ensuring the access to hospital care for the poor and the working poor of New Jersey. In the local community we immediately saw the impact of the system as the issue of patient dumping (transferring poor patients from one facility to another hospital) for the most part ceased to exist. In addition as indigent care was recognized as a cost, inner city hospitals, who bear the brunt of indigency, were able to catch-up in both physical plant and technology with their suburban counterparts. In catching up, the urban hospitals were able to provide state-of-the-art facilities and services to their communities, a significant portion of whom are indigent. In providing equal access to state-of-the-art hospital services to all of its residents, the State of New Jersey has shown itself to be one of the most progressive states in the country and it should be commended.

With the potential loss of the federal waiver and the resultant non-payment of indigent care by Medicare, the progress that New Jersey has made in providing hospital care to the indigent will be erased almost overnight. The practice of patient dumping may reoccur (I refer to the attached article from the New England Journal of Medicine that describes some of the consequences of dumping). The hospitals that bear the brunt of poor patients will once again fall behind their suburban sisters.

In examining the options that the State can pursue in maintaining its very progressive policies in terms of the provision of hospital-based indigent care, there are a number of issues that the Committee should keep in mind.

- The new system should continue to ensure that the indigent have the ability to go to the hospital of their choice.

- The new system should spread the costs of indigent care in as equitable manner as possible. One of the purposes of our all-payor system was to spread the costs of indigency among all users in an equitable manner as possible. There are some inequities in the current system in that users of hospitals with highest levels of uncompensated care are paying more for care than users of hospitals with the lowest levels of uncompensated care. In designing a new system we should try to correct these inequities.

- A new system should provide incentives to allow substitution of less costly ways of providing care such as ambulatory surgery for inpatient care.

- The new system for payment of hospital-based indigent care should maintain our current all-payor system. The maintenance of this system will be to prevent the cost-shifting that is currently occurring in the hospital industry in many states. In cost-shifting one group of hospital users either by insurance coverage or employments end subsidizing care provided to other groups, whose hospital payment is fixed as in the Medicare DRG system or whose provider group such as Preferred Provider Organization or Health Maintenance Organization receive discounted rates.

In conclusion, let me reiterate the importance of the issue with which you are beginning to deal. Due to its importance, we must all work together to insure that the progress that we have made in providing hospital care to the indigent is maintained and that New Jersey will continue to be a leader in developing health care policies and programs that ensure that all of its residents have access to high quality health care services.

Sincerely,

Dennis G. Cherot
President

Newark

Kenneth A. Gibson
Mayor

Department of Health and Welfare

110 William Street
Newark, New Jersey 07102
201 733-6430

Dennis G. Cherot
Director

March
24th
1986

Honorable Joseph Colburn, Jr.
Chairman
Assembly Health and Human
Resources Committee
CN 068 State House Annex
Trenton, New Jersey 08625

Dear Assemblyman:

I am most appreciative of this opportunity to offer some comments on the vital issue of the provision of hospital-based indigent care.

The Newark Department of Health and Welfare provides quality health care services to the indigent population of the City of Newark and as Director of the Department of Health and Welfare, I am very much concerned about the provision of indigent care and its accessibility to residents of our city.

A major step in ensuring the access to hospital care for the poor and working poor of New Jersey was the development of the state's all-payor DRG System with its inclusion of uncompensated care to the indigent as an expense to be paid by all users of the hospital. On the local level, we immediately saw the impact of the system as the issue of patient dumping, for the most part, ceased to exist. Additionally, as indigent care was recogized as a cost, inner-city hospitals, who bear the brunt of indigency, were able to catch-up in both physical plant and technology with their suburban counterparts. Because of the DRG System, urban hospitals are now able to provide state-of-the-art facilities and services to their communities, a significant portion whom are indigent. The State of New Jersey should be commended for providing equal access to quality health services for all its residents.

We can not allow all the good that has been accomplished through the DRG System to end. With the potential loss of the federal waiver and the resultant non-payment of indigent care by medicare, the progress that New Jersey has made in providing hospital care to the indigent will be erased almost overnight.

Patient dumping may reoccur. The brunt of caring for poor patients will fall on the urban hospitals.

In maintaining its very progressive policies in terms of the provision of hospital-based indigent care, these are a number of issues that the committee should keep in mind when examing the options.

- Any new system should ensure that the indigent be able to go to the hospital of their choice.

- Costs of indigent care should be spread in an equitable manner. There are some inequities in the current system in that users of hospitals with the highest levels of uncompensated care are paying more for care than users of hospitals with the lowest levels of uncompensated care. In designing a new system we should try to correct these inequities.

- Incentives to allow substitution of less costly ways of providing care, such as ambulatory surgery for impatient care, should be included in this system.

- The new system of hospital-based indigent care should maintain our current all-payor system. The maintenance of this system will be to prevent the cost-shifting that is currently occuring in the hospital industry in many states. In cost-shifting one group of hospital users either by insurance coverage or employment, ends subsidizing care provided to other groups, whose hospital payment is fixed as in the Medicare DRG System or whose provider group such as Preferred Provider Organization or Health Maintenance Organization receive discounted rates.

In conclusion, due to the importance of the issue at hand, I feel we must all work together to insure that the progress that we have made in providing hospital care to the indigent be maintained and that New Jersey remain the leader in developing health care policies and programs that ensure access to high quality health care services to all its residents.

Sincerely,

Dennis G. Cherot, Director
Department of Health and Welfare