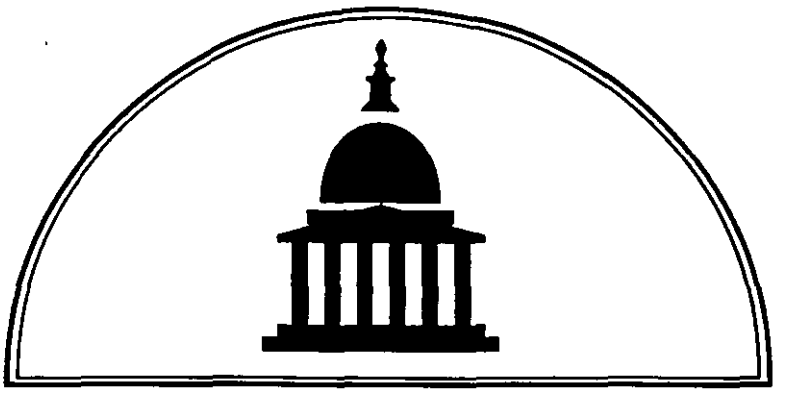

Maintaining A Commitment —

Access to Hospital Care

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MAINTAINING A COMMITMENT—ACCESS TO HOSPITAL CARE

An issue brief prepared by Professor Jeffrey Merrill
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In May of this year, Federal District Court Judge Wolin struck down the New Jersey hospital reimbursement system, known as Chapter 83. In a decision that was more far-reaching than expected, the Judge not only ruled that the method by which New Jersey paid for uncompensated hospital care---a 19 percent surcharge on all hospital bills---violated ERISA, the Federal employee benefit law, but that all of Chapter 83 was "unenforceable."

Essentially, the Judge's ruling was based upon the fact that the Federal ERISA statute precludes state laws that infringe upon employees' benefits. He argued that the fact that the state had set rates and surcharges on hospital bills paid by union health and welfare funds constituted such an infringement.

The implementation of Judge Wolin's decision was subsequently delayed until November 30, and is currently under appeal in the Third Circuit Court. Some expect that his ruling may be narrowed, striking down only the surcharge for uncompensated care, leaving the remainder of Chapter 83 intact. Nevertheless, events have placed the future viability of New Jersey's rate setting system in question regardless of the Court's decision. For example, the withdrawal in 1988 of Medicare from the all-payer rate-setting system[1], the increasing differential enjoyed by both Blue Cross and Medicaid, and the growing competition for hospital discounts from both HMOs and other insurers, have all placed Chapter 83 under increasing pressure. Thus, even if the Judge's ruling is reversed by the Circuit Court, there is a growing realization that reform, if not overhaul, of Chapter 83 is required.

[1] All-payer rate-setting system means that all insurers, public and private, pay according to the same rules.

BACKGROUND

Before discussing the future hospital payment system in New Jersey, it is helpful to provide some background on the current system. Chapter 83 went into effect in the early 1980s. Essentially, it's goals were three-fold:

1) To assure access to hospital care for those New Jersey citizens who did not have health insurance and who could not afford the cost of such care. This was done by adding a surcharge on to every hospital bill and using that pool of funds to pay for uncompensated care for the poor and uninsured.
2) To contain cost while keeping hospitals financially viable. This was achieved through the use of a fixed price for care, using diagnosis related groups (DRGs)[2] as a mechanism for equitably pricing the cost of a hospital stay. By paying a prospective fixed price, rather than reimbursing hospitals retrospectively for their costs, incentives were built into the system for hospitals to be more efficient in the care they provided.
3) To create equity among payers. Under Chapter 83, all payers including commercial insurers, Blue Cross, Medicare, and Medicaid were to pay rates that were reasonably close to each other. Prior to Chapter 83 there had been a growing disparity between the amounts that were paid by commercial insurers (including HMOs) and those paid by Blue Cross. Commercial payers which reimbursed based on hospitals' charges were paying about 30 percent more than Blue Cross which was paying costs. This was because hospitals were using charges to shift the cost of uncompensated care. Under Chapter 83, since this cost was now spread across all payers, private insurers---including self-insured corporations---actually bear less of the burden.

PROGRESS TOWARD GOALS:

Access

In most ways, Chapter 83 fulfilled these goals. Research indicates that access to hospital care greatly increased for many New Jersey citizens who, before, might only have been able to receive care in public institutions which traditionally took care of this indigent population. After Chapter 83 was adopted, individuals unable to pay for care were much more welcome at all

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[2] DRGs are a method whereby related diagnoses are grouped in similar categories.

hospitals around the state because hospitals would now be paid for their care. In addition, for a period of time, the system did provide much more equity among the various payers. While some differentials continued to exist, these were much less than the disparities that existed prior to Chapter 83. Unfortunately, when Medicare pulled out of the all payer system in 1988 and Medicaid reduced its reimbursement levels, increased disparity between these public payers, the commercials, and Blue Cross began to increase again. With the advent of managed care, the use of discounting by many payers has grown and disparities among payers have increased further.

Cost-Containment and Payer Equity

With regard to containing cost, evidence indicated that Chapter 83 has also met its goal. Hospital costs in New Jersey compare favorably with the region and the rest of the country. In 1980, the average cost per admission for New Jersey hospitals was approximately the same as the national average. Over the next ten year period, while the national average cost per admission rose by 166.3 percent, costs in New Jersey rose only by 147.2 percent. In fact, New Jersey's average cost per admission in 1990 was the lowest of any state in the Northeast and Mid Atlantic regions. Moreover, in 1990 hospital expenses in New Jersey as the percent of the gross state product (GSP) were 2.9 percent while, for the country as a whole, they were 3.6 percent. Lastly, hospital costs as a percentage of personal income was only 3.7 percent in this state, while it was 5 percent in New York and 5.7 percent in Pennsylvania. New Jersey ranked 47th out of the 50 states in this measure. Thus, despite providing access to hospital care for all citizens (a fact that is not the case in almost any other state) and keeping the hospitals financially viable, Chapter 83 appears to have maintained its goal of containing cost, at least as compared not only to our neighboring states, but to the rest of the country as well.

COMPETITION VS. REGULATION

As we consider what directions to move with regard to the hospital payment system in New Jersey, the debate appears to center on the question of whether we want to continue the current regulatory system or move to a more competitive environment. Clearly, there is considerable appeal to moving in the direction of infusing much greater competition into the system. Competition conforms to the American orientation towards a capitalist system and reduced government intervention in the marketplace. It reduces the bureaucracy needed to run the system and the burdens imposed by government. It permits payers to negotiate their own best deals,

forces hospitals, at least in theory, to be more efficient in order to remain competitive, and can force inefficient hospitals from the system. Lastly, a purely competitive model would obviously comply with Judge Wolin's decision and not violate the provisions of ERISA.

On the other hand, competition can threaten the financial stability and even the survival of some hospitals. This is particularly so for those hospitals which treat a high percentage of the poor and uninsured, are urban teaching facilities, or are low occupancy rural hospitals. While competition may remove inefficient hospitals from the system, it also runs the risk of removing needed hospitals from that system, particularly the ones just described. A competitive system also can lead to a reduction in needed services which are either viewed as not profitable to a hospital or may be a disadvantage to it in a competitive marketplace, most particularly emergency and trauma services.

Also, ironically, the experience to date around the country has indicated that competition has not been particularly successful in containing cost. As already described, the New Jersey regulatory system has done well when compared with states where the system is more deregulated. The reasons for this are complex. There is, for example, evidence that hospitals in a competitive market compete not so much on price but on the services and amenities they offer. Such services and amenities often add considerably to hospital costs, by forcing increased capital expenditures and the proliferation of technology.

Another reason that competition has not proven an effective cost-containment strategy is that hospitals raise charges artificially and grant discounts from those inflated levels. This is somewhat akin to department store sales offering 20 percent off prices that have already been increased by more than that amount. Lastly, while some payers with a large market share can gain significant discounts under a competitive system, hospitals are often forced to compensate for this revenue shortfall by raising their charges even more to other payers who have less purchasing power. This can cause significant inequities across payers and often penalizes small businesses and individuals who cannot gain any market leverage.

At the same time, there are advantages and disadvantages in a regulatory approach. On the positive side, the system in New Jersey has managed to preserve universal access to hospital-based care for more than a decade. In addition, it has assured the financial solvency of needed hospitals,

such as those serving the poor, teaching hospitals, and inner-city institutions. A regulatory system can also address the issues that plague hospitals with regard to creating a level playing field, including such issues as teaching, the Medicare shortfall, and uncompensated care. Lastly, as already discussed, the regulatory model has maintained some equity among payers and has kept New Jersey's health care costs below the regional and national levels.

On the other hand, the regulatory model also has some disadvantages, the most notable of which is that it requires continued government interference in the marketplace and adds bureaucratic cost to the system. In addition, it can maintain not only the financial viability of needed institutions, but of those which may be inefficient and of less utility to the community. The system as currently structured provides incentives for the use of hospital-based services, as opposed to encouraging more preventive and lower cost community-based care. Lastly, continuation of either the current system or one which involves much government interference could be deemed out of compliance with the ERISA prohibitions and may not be possible under the Wolin decision.

FUTURE ACTIONS

Clearly there is considerable latitude---and debate---on the choices that may be made with regard to how the New Jersey hospital payment system is structured. Whatever decisions are made, it is important that those deliberations include a full understanding of how Chapter 83 has functioned in the state with regard to both assuring access and containing costs. This requires an objective discussion of both its successes and shortcomings. It is important to be aware of how a more competitive environment has functioned in other states in terms of its impact on costs, on access to care for the poor and uninsured, on such services as emergency room and trauma care, and on medical education. Modifying or overhauling the payment system in New Jersey should be viewed as an opportunity to make real changes geared towards learning from our mistakes, correcting the deficiencies in the current system, infusing more competition into that system, while maintaining the state's commitment to assuring access to all its citizens. Change for change's sake is not a desired outcome. Change to promote greater efficiency and equity, on the other hand, is what is desired.

ONE LAST NOTE

While much of the debate to date has focused on the question of hospital payment and uncompensated care, it is difficult to separate out this payment discussion from the broader issue of health care financing. Currently, access to health care for the poor and uninsured is being addressed through the payment system rather than through the financing---or health insurance---system. While Chapter 83 has done a good job of assuring access to hospital-based services for the poor and uninsured, it represents an inefficient mechanism to achieve the goal of a financing system. The current payment system 1) raises real concerns about how to separate true charity care from bad debt; 2) has created a bureaucratic and administrative nightmare for hospitals in terms of the requirements for documenting their uncompensated care burden; and 3) has created incentives for care to be provided in expensive hospital settings rather than through more economical community-based providers. These problems exist with or without the Wolin decision. Thus, rather than solely debating whether the uncompensated care fund should be extended and for how much and for whom, it is important to remember that expanded health insurance coverage could address a significant part of these problems. One obvious question is whether the funds that are currently going to support uncompensated care might be more efficiently and effectively used to provide subsidies for individuals who cannot afford all or part of their insurance premiums. From a number of studies, it is evident that such subsidies would leverage those dollars and, potentially, provide for significantly more coverage per public dollar spent than the current system does. For example, $400 million would be sufficient to subsidize the cost of insurance (including coverage for ambulatory care), on a sliding scale basis, for all those who were under 250 percent of poverty, far less than the $750 million spent this year on uncompensated care.

While this estimate is an approximation, the fact remains that the payment system is a burdensome and inefficient means of guaranteeing access. On the other hand, the health financing system, through expanding insurance coverage is a more efficient mechanism. It should be noted, however, that while simple subsidies to those unable to pay the full premium costs might help alleviate the problem, they will not be sufficient to gain anything near universal coverage for New Jersey's citizens. As has been debated over the last couple of years, there is also a need for real insurance reform to achieve this. This reform can take many forms, but might include such approaches as some form of community or demographic rating, guaranteed issue (the guarantee that anyone who applies for insurance will be able to get it), guaranteed renewability, and some

form or combination of incentives or sanctions on employers for not providing coverage. While not advocating any of these specific approaches, it is important that a debate over the questions of maintaining access to care for all of the New Jersey's citizens includes these issues.

As one travels around the United States, it is evident that the New Jersey system has been viewed as model of both cost containment and expanded access. No other state (with the possible exception of Hawaii) has made such a commitment to its citizens. The current problems with Chapter 83, the Wolin decision, and the debate over insurance reform should not be viewed as a burden; rather, they represent a real opportunity and challenge to both the Governor and the Legislature to build upon the current commitment and system, and maintain New Jersey as a true model for other states as they also consider these same difficult issues.