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State Model: New Jersey

Long-Term Experience With All-Payer State Rate Setting

by Kevin G. Volpp and Bruce Siegel

In the mid-1980s New Jersey thought it had found a way both to control rising costs and to provide access to health care for the uninsured. The New Jersey all-payer rate-setting system, under which an uncompensated care mechanism was created to pay for hospital care for the uninsured, seemed to control costs while improving access. The withdrawal of Medicare from the all-payer coalition in 1988 strained the system too far, however. Its end came quickly on the heels of a May 1992 U.S. District Court decision, which ruled that the system was in large part preempted by the Employee Retirement Income Security Act (ERISA) of 1974.

Rate-setting mechanisms such as New Jersey's have received attention from would-be reformers due to their success in moderating the growth in hospital costs while increasing access to care.¹ In addition, all-payer rate setting has been able to reduce the amount of cost shifting between payers and to restore the financial solvency of inner-city and teaching hospitals.² It is generally acknowledged that the programs in states where regulatory models have been in place for several years have been most successful in containing costs and in minimizing cost shifting.³ All-payer rate setting in countries such as Germany has been used successfully for hospitals and physicians for many years.⁴

In recent years attempts by state governments to deal with access problems have

been largely stymied by fiscal constraints and recessionary times and by the provisions of ERISA, which may preempt any actions by states that affect self-insured benefit plans. Meanwhile, controls on Medicare payment levels have placed a larger burden on other payers and also have strained the viability of state-level all-payer systems.

Health Reform In New Jersey

New Jersey made its first major foray into government regulation of health care with the passage of the New Jersey Health Care Facilities Planning Act in 1971. The act, which established both mandatory certificate-of-need (CON) health planning and hospital rate controls for Medicaid and Blue Cross, was passed in response to public anxiety over medical inflation and garnered the support of hospitals, which hoped to restrain the entry of new competitors from out of state. The next major step came with the passage of legislation in 1978 (Chapter 83), which extended the rate-setting system over all payers and hospitals, making explicit reference to the cost of uncompensated care as an "allowable financial element." It was believed that without equity among payers and the explicit recognition of bad debt and charity care, large-scale cost shifting would result in an untenable position for disenfranchised patients and for the hospitals that treated them, as well as for commercial payers, who were bearing an increasing share of these costs through rising hospital charges. The inclusion of uncompensated care as an allowable cost gave Chapter 83 the political support it needed from urban hospitals.

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Chapter 83 also allowed the creation of a diagnosis-related group (DRG) prospective payment methodology as a federal demonstration project. Hand in hand with this demonstration came a federal waiver under which Medicare paid New Jersey hospitals according to the new rules and rates of this system. By 1982 all New Jersey general hospitals were billing by DRGs, with a hospital-specific markup to cover the costs of uncompensated care. Rates at each hospital were increased in accordance with how much uncompensated care it provided. While the new system quickly stabilized the financial situation of the inner-city hospitals that had been providing large amounts of uncompensated care, many inner-city hospitals also found that their percentage of uninsured patients necessitated markups as high as 25 percent, placing them at a significant competitive disadvantage.⁵ The hospital-specific markups meant that paying patients had an incentive to go to hospitals that delivered less uncompensated care, which exacerbated rate differentials by concentrating increasing amounts of uncompensated care in a few urban institutions.

To respond to the concerns of "uncompetitive" hospitals, the New Jersey state legislature created an Uncompensated Care Trust Fund (UCTF), whereby a uniform uncompensated care charge would be added to all hospital bills in the state starting in 1987. Hospitals that received a surplus of funds deposited the surplus into an account from which hospitals with higher uncompensated care burdens could draw. Thus acute care institutions were assured of receiving reimbursement for all care they delivered without being placed at a competitive disadvantage, while the uninsured were assured full access to hospital care. Although the legislative creation of the trust fund achieved certain equity objectives, it also transformed uncompensated care into a volatile statewide political issue in the legislative arena. Details of the original rate-setting legislation had been developed through administrative regulation. As health care costs and cost shifting continued to rise, this would have critical implications.

Stresses on the system. In early 1983 the

federal government adopted the Medicare prospective payment system (PPS). The new federal controls on hospital payments and annual rates of increase made it increasingly difficult to meet the cost-neutrality or savings requirements of the original federal waiver. As the federal government began to restrict Medicare's rate of increase, it became clear that Chapter 83 rates, which included uncompensated care, were much higher than PPS rates. In 1989 the waiver was terminated, and Medicare payment rates for New Jersey hospitals reflected the national PPS methodology. As a result, other payers were forced to make up the "Medicare shortfall" in the rates they were charged. By 1991 this cost shift to non-Medicare patients amounted to \$710 million.

A further stress on the system was a continued rise in the number of uninsured residents, mirroring the national trend. By 1990 the number of uninsured persons in New Jersey approached 900,000. Much of the economic expansion in the 1980s had been in service industries and small businesses, which are less likely to insure their workers. Empirical work also has shown that the presence of uncompensated care trust funds may discourage the purchase of private insurance.⁷ This is probably due to both the greater availability of hospital-provided free care to the uninsured and the higher premiums caused by uncompensated care markups (by 1990 New Jersey insurers were paying a surcharge of 19 percent on all hospital bills to finance the UCTF). These factors seemed to create a cycle in which, over time, fewer and fewer people were likely to be insured.

The biggest limitation of the New Jersey UCTF, however, may have been its focus on hospital-based care. The trust fund provided reimbursement to general hospitals only. In contrast to nationwide statistics that show that the uninsured use 47 percent less hospital care than the insured, the uninsured in New Jersey in 1990 used an estimated 30 percent more hospital care than the insured.⁸ Given the full reimbursement for hospital-based care, it is not surprising that the uninsured used higher-cost hospital-

based services rather than lower-cost com-

munity-based care.

Various markers of health status suggest that primary reliance on a hospital-based system has adverse health implications for the medically indigent. In 1988 up to four-fold variations in admission rates were seen among poorer and wealthier areas of the state, and utilization rates varied even more. Per capita costs of treating ambulatory care sensitive admissions also varied accordingly.⁹ Recent studies show that New Jersey has the highest rates of hospitalization among twelve states surveyed for conditions preventable with appropriate primary care. But this also reflects poorer access to primary care.¹⁰ Despite a huge investment in treating the medically indigent, these numbers indicate that the UCTF had done little to make people healthier, as the primary care structure remained underdeveloped. While lifestyle and other factors probably affect these numbers, the dysfunction in primary care may indicate the shortsightedness of financing the care of the medically indigent solely in hospitals.

The focus on hospital-based care was problematic for other reasons as well. The guarantee of full reimbursement for uncompensated care to hospitals caused a disincentive for hospitals to collect payments aggressively, since by writing off uncollected payments as "bad debt" they were guaranteed full reimbursement. Many charged that rather than ensuring access, the UCTF was primarily assuring hospital solvency. By 1989 more than 80 percent of trust fund payments were reported to cover bad debts, while less than 20 percent went to pay for the care of individuals who had met the state's charity care guidelines.¹¹ These percentages were certainly distorted, as the bad debt proportion was inflated by difficulties in obtaining documentation for charity care eligibility. Nevertheless, the UCTF was increasingly perceived as a fund for deadbeats who failed to pay their bills and for hospitals too lazy to collect.

By 1990 it became clear that the UCTF was no longer sustainable in its current form. The removal of Medicare as a contributor meant that the "hidden tax" was all but hidden to those forced to pay it. The com-

plexity of the state's rate-setting system also meant that a logjam of as many as six years of unresolved rate appeals and final reconciliations burdened the system. What had been a special appeals process to respond to extraordinary cost increases at individual hospitals became a morass in which as many as 2,000 annual rate appeals were filed by the eighty-five general hospitals in New Jersey. By applying political pressure, hospitals often were able to get favorable concessions. In April 1990 newly elected Governor Jim Florio appointed a Commission on Health Care Costs to examine the components of New Jersey's health care system as they related to cost and access.

The Next Stage Of Reform

Commission recommendations. The governor's commission issued a series of recommendations designed to deal with the limitations of the UCTF and the rate-setting system. Principal among the recommendations were the introduction of a broad-based financing approach for uncompensated care and the conversion of the trust fund from a payer of bills to an insurance mechanism. A 1 percent payroll tax on the first \$14,400 of income coupled with "play-or-pay" employer penalties of \$1,000 for every uninsured employee were suggested as a more fair way to finance uncompensated care. Revenue from the payroll tax would be used to help support publicly sponsored health insurance plans, which would partly replace the trust fund. The commission decried the focus of the UCTF on hospital-based care and suggested that a shift in focus to preventive and primary care in non-hospital settings would both save money and improve health.

A further recommendation was to create a state health plan with the force and effect of state law to assess new investments in all health facilities and services. Although hospital facilities and services were regulated in New Jersey, this partial regulation had mixed results at best. It was estimated that in 1990, although there were perhaps eighteen magnetic resonance imaging (MRI) ma-

chines in New Jersey hospitals, more than fifty existed in unregulated physician practices. In addition, the commission suggested folding capital investment into DRG rates and rebundling payment for hospital specialists into the rates.

As stipulated by law, the trust fund was due to expire 31 December 1990. However, this date passed without consensus on how to reform the system of financing uncompensated care. The commission's payroll tax recommendation failed to pass amidst the backlash after the increase in New Jersey's income and sales taxes earlier in 1990. Legislators refused simply to extend the trust fund until agreement could be worked out on a broader vision of how to ensure access while controlling costs. Given the stipulated trust fund expiration date, the Department of Health was required to reintroduce hospital-specific surcharges, similar to the method of paying for uncompensated care that had existed before 1987. Five years later, however, with hospital costs much higher and Medicare no longer paying its share of uncompensated care, the surcharge for some inner-city hospitals ran as high as 78 percent, raising fears that the few insured patients in such hospitals would be driven away.

A partial answer. Temporary relief for the crisis came with the passage of Chapter 187, the Health Care Cost Reduction Act, in the summer of 1991. This bill contained a package of reforms that addressed some significant problems with the UCTF but that failed to address the overall financing crisis. In signing the bill into law 1 July 1991, Governor Florio heralded the bill as "New Jersey leading the way," although simple extension of the UCTF (now called the Health Care Trust Fund) for another year meant that the crisis was far from resolution. The main thrust of Chapter 187 was a shift in focus away from hospital-based care. A tax of 0.53 percent on hospital revenues, which was projected to raise up to \$40 million annually, was targeted toward expansion and enhancement of primary care services under the premise that care for the poor and uninsured can be delivered at higher quality and at lower cost in community-

based primary care settings than in hospitals.

Among the other provisions of the act were the expansion of Medicaid eligibility up to 185 percent of the federal poverty line for women and children under age six, a physician and dentist loan redemption program for providers in underserved areas, and a strengthening of health planning and certificate of need. This last item was to lead to a full-blown battle between the legislative and executive branches as five general hospitals were recommended for conversion to other uses. Although important provisions, none of these dealt head-on with the issue of financing uncompensated care, leaving that battle for a later day.

Crisis in 1992. That day came perhaps not sooner than expected but in a very different guise. A group of unions filed suit, charging that the surcharges placed on hospital bills paid by their self-insured health and welfare funds forced them to pay for health care for people who were not union members-an alleged violation of ERISA.¹² In his statement 27 May 1992, Judge Alfred M. Wolin of the Federal District Court in Newark ruled that ERISA preempted some provisions of the New Jersey hospital rate-setting law, including the shifting of costs to pay for indigent care, bad debts, and low levels of Medicare reimbursement.¹³ The ruling affected both the unions that brought the lawsuit and all other self-insured entities. Although a stay was granted, it became clear that a major restructuring of New Jersey's health care regulatory scheme was in the offing.

The governor had already been pushing for other reforms in the small-group and individual insurance markets-namely, open enrollment, community rating, and limitations on preexisting condition exclusions. While such changes might help more people to obtain health insurance, a significant number of people would still be uninsured, and the need to finance hospitals' uncompensated care would remain. Meanwhile, the state legislature scrambled to find some way to cover these costs through an external source. Sales tax hikes, income tax increases, and "sin taxes" on tobacco and alcohol were all proposed. The governor's

commission payroll tax recommendation was also discussed. Little consideration was given to a broader approach such as universal health insurance through a play-or-pay or employer-mandated mechanism because of a political climate that had turned hostile to regulation of the health sector. In the fall of 1991 both the state Senate and the Assembly changed from Democratic majorities to Republican, and Governor Florio found himself confronted with a frequently hostile, veto-proof Republican legislature elected on a strong antitax platform. Reform was about to take place in a political atmosphere that would virtually dictate certain outcomes.

The plan that emerged. The end result came 30 November 1992, when after an extraordinarily brief hearing period, the state legislature passed a controversial package of reforms, the Health Care Reform Act (HCRA) of 1992. The act was immediately signed by the governor, who maintained that it was the best legislation he could get under the circumstances. Under the legislation, price regulation and the DRG system ended, with hospital revenue caps to remain in place for a one-year transition period only. Hospitals' ability to offer discounts to competitive bidders was dramatically increased, and the old Chapter 83 provisions guaranteeing "efficient" hospitals their "full financial elements" were repealed.

One of the most controversial aspects of the HCRA was the tapping of the New Jersey Unemployment Insurance Trust Fund surplus for \$500 million annually to cover the costs of charity care at most of the state's hospitals. The formula for distributing these funds, however, gives nearly all hospitals a piece of the pie, meaning that hospitals with truly high uncompensated care loads will not receive as much help as they need. An additional \$100 million was diverted from the fund in the first year to subsidize hospitals with large Medicare patient loads.

In subsequent years the charity care dollars are to be used to fund a "Jersey Shield" program, which is a subsidized managed care insurance plan for the state's uninsured citizens. Funding for this is to reach \$200 million annually by 1997. These programs all will be run by a newly formed Essential

Health Services Commission, which is also to study cost and quality of hospital care.

Most opposition to the HCRA has come from organized labor, which opposed the Unemployment Insurance Trust Fund diversion, and the state's urban hospitals. These hospitals, which had benefited from the Chapter 83 guarantees of solvency and the old statewide surcharge method of covering uncompensated care, felt very threatened by these new procompetitive policies. Some urban hospitals project multimillion-dollar shortfalls, as their new charity care subsidies will fall far short of their collections from the now defunct UCTF. These shortfalls cannot be shifted easily to their few paying patients, for fear of driving them away. Many urban hospitals have recently quit the New Jersey Hospital Association (which supported the HCRA) and have formed a new group, the Hospital Alliance of New Jersey. Meanwhile, suburban hospitals and their (often Republican) legislators celebrated the dawning of a new era in which they will be able to compete on price. Hospitals with lower uncompensated care loads may be able to greatly increase market share once competitive bidding by large insurers takes hold. Many foresee potential financial disaster for New Jersey's inner-city hospitals. Veterans of the heyday of the New Jersey regulatory system have commented on the irony of a state turning away from regulation just as the concept was again coming into vogue in other states.

Lessons From New Jersey

Minimize cost shifting. It is clear that cost shifting among payers (the most common form of "cost control" today) must be minimized for a rate-setting system to remain viable. In New Jersey the withdrawal of Medicare as a contributor to uncompensated care payments and Medicare's emergence as a payer whose payments had to be subsidized broke the back of an originally stable system. Much of this was manifested by the realization of individuals and payers that an ever-increasing portion of their hospital bills was earmarked to pay for the care

of someone else, leading eventually to the union lawsuit. Ironically, while cost shifting precipitated the lawsuit, under the deregulated system featured in the HCRA legislation, cost shifting will probably be even more common. The prospect of even more stringent national controls on Medicare may make rate setting even more difficult. For a regulated system to function, cost shifting needs to be avoided or tightly controlled.

Include appropriate incentives for providers. By guaranteeing hospitals 100 percent reimbursement for all uncompensated care, the UCTF gave hospitals too little incentive to collect bad debts and to cooperate with the state in enrolling eligible uninsured persons in Medicaid. The extent of the problem was finally revealed by findings that 80 percent of the trust fund dollars went to bad debt, while only 20 percent went to charity care. The numbers may look worse than the reality, as many patients whose bills were classified as bad debt might have been eligible for charity care, although they were never so designated. Nevertheless, stronger incentives for hospitals to collect bad debt and to enroll the uninsured in Medicaid should have been in place. Any system that appears to enrich hospitals and give some persons a free ride will spark vocal opposition.

Use financial incentives to encourage primary care. Not surprisingly, the availability of free care in hospital-based settings drove the uninsured to seek care in hospitals rather than in more cost-effective settings. As mentioned above, uninsured persons in New Jersey use much more hospital care than their counterparts in other states. Chapter 187 began to shift the focus of the trust fund away from hospital-based care, but only after years of pouring billions of dollars into a hospital-based system for treating the medically indigent. Unless the right financial incentives are in place, reforms aimed at encouraging preventive and primary care will accomplish little.

Shield state regulators from the pull of partisan politics. For regulation at the state level to be an effective means of cost control, regulators must be able to withstand the political pressure that comes with unpopular

decisions. The history of rate setting at the state level, however, is one of appeals of one kind or another and of rate relief granted to hospitals that complained loudly that their rates were too low. While rate setting and the UCTF were intended to guarantee hospital solvency, holding rates down to a level approximating costs was also supposed to weed out inefficient providers. However, not a single hospital has become insolvent since the rate-setting system went into effect in the early 1980s. When Department of Health staffers perhaps a bit ingenuously suggested in 1992 that five underused hospitals be shut down as part of the state health plan, the protests of local legislators and lobbyists resounded. The New Jersey rate-setting bureaucracy, a part of the state Department of Health, also was never fully insulated from political pressure. The smaller size of states and the greater ability of lobbyists or other hospital representatives to make known their dissatisfaction with regulatory decisions make it difficult, if not impossible, for state regulators to stand firm in their resolve to make painful but necessary cuts in the system.

Count the political costs of health care reform. In the initial years of the New Jersey regulatory system, the legislature was rarely involved with day-to-day hospital payment issues. The regulatory approach was only possible, however, when the costs of uncompensated care were small enough to hide. As the UCTF grew, it became increasingly difficult to achieve meaningful reform through the political system, as few politicians wanted to be associated with new taxes of any stripe. This has important political implications for politicians and policymakers designing ways to finance care for the indigent. In the end the New Jersey legislature opted for what seemed to be a "no new taxes" solution, which few observers expect to survive very long. Indeed, by tapping the Unemployment Insurance Trust Fund for \$600 million in the first year of the HCRA, the legislature essentially replaced private dollars with a publicly financed subsidy. The political realities of state governance dominated any attempts at "good" health policy reform.

Conclusion

The New Jersey experience is perhaps the most acute example of what can happen when a state attempts to "piggyback" a universal access scheme on a fragmented system based on private employment insurance, Medicaid, and Medicare. As long as these entities act out of concert, some people will wind up picking up the tab for others. This will rarely be sustainable. Indeed, the current thrust toward managed care and managed competition may exacerbate these inequities as better-organized payers negotiate deeper discounts for themselves, leaving others to pay the difference. Such a financial framework may help some insurers and hospitals in the short run, while doing little to improve access to primary care and to keep people from requiring hospitalization. Reform efforts will continue to founder on these obstacles as state politics intervenes to make reform a halting process at best.

The Clinton administration would do well to heed these experiences. Incremental reform, based on the current American system of health care finance, could replicate the New Jersey experience, with unfortunate results. A poorly insulated regulatory bureaucracy, trying to maintain a system of cost shifts and controversial public subsidies for a subset of people and providers, stands little chance of fundamentally improving a flawed health care framework. If the New Jersey experience is any indication, government-sponsored cost shifting between politically powerful entities will not last and will not achieve the desired health outcomes. Instead, we need to question the piecemeal nature of our health system. Can a system in which people's access to care is determined by where they work and live, their age, or their income ever be rationalized by trying to bring these pieces together into a coherent whole? A paradigm based less on filling gaps, and more on universality and equity in access to basic services, may have a much better chance of succeeding.

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