

# Setting New Jersey Hospital Rates: A Regulatory System Under Stress

*Bruce Siegel, M.D., M.P.H.†*  
*Anne Weiss, M.P.P.‡*  
*Diane Lynch, J.D., M.S.†††*  
*New Jersey Department of Health\**

## I. INTRODUCTION

New Jersey's system of hospital rate setting<sup>1</sup> is a unique response to a common set of health care problems faced by many states. Such problems include the growing number of uninsured, explosive health care cost increases, and an organizational structure that delivers health care services in multiple and overlapping settings. States have responded to these problems in different ways,<sup>2</sup> but New Jersey was one of the few states to attempt to create a state-operated system of rate regulation that encompasses all payers<sup>3</sup> and all hospitals while assuring that these hospitals receive reimbursement for all uncompensated care<sup>4</sup> they render. This unique system evolved

---

† Dr. Siegel is the Executive Director of the New Jersey Office of Health Policy and Research and, in that capacity, will oversee the creation and implementation of the New Jersey State Health Plan. He is a fellow of the New Jersey Academy of Medicine.

‡ Ms. Weiss is the Director of Hospital Reimbursement for the New Jersey Department of Health.

†† Ms. Lynch is the Chief of Staff for the New Jersey Department of Health.

\* Any opinions expressed herein are those of the authors and are not to be construed as the views of the New Jersey Department of Health or any other official agency.

1. Hospital rate setting generally refers to a statutory or regulatory system that sets the rates hospitals can charge some or all patients. Typically, the legislature grants significant regulatory authority to a state agency. Hospital rate setting is perhaps most closely related to public utility regulation.

2. One common approach taken by many states in the last two decades is to regulate the rates charged by, or the costs incurred by, hospitals. More recently, a number of states have experimented with approaches to extend health care coverage to the uninsured, such as subsidizing low-cost insurance or developing insurance mechanisms that "pool" the higher health risk facing some individuals.

3. A "payer" is a Blue Cross plan, insurance company, employer plan, government program, or any other entity paying for health care services. The term includes patients responsible for their own bills.

4. "Uncompensated care" refers to charges for which hospitals are not reimbursed

slowly over several decades, becoming increasingly sophisticated and complex as it was transformed from a voluntary process covering only a few payers to a mandatory form of regulation with far-reaching effects. In time, the New Jersey system would also serve as an experiment in a radically different form of reimbursement, one which would later be adopted by the nation's largest insurer, the Medicare program.<sup>5</sup>

Despite its growth, this is by no means a story of the system's success. It is a story of a system which may have briefly achieved its goals in the mid-1980's, but which is now under the extreme pressure of medical indigency, cost inflation, and, perhaps most important, the end of federal participation.

This Article reviews the history of hospital rate setting in New Jersey, emphasizing the system's evolution in response to newly perceived problems and changing political forces. The system experienced some early success in controlling cost growth and demonstrating new techniques of hospital rate setting. In later years, rate setting in New Jersey has been less successful at confronting a new federal role and the growing problem of health care access. The problems faced by New Jersey hold lessons for both the federal government as it pursues cost containment and the other states who either operate rate regulation systems or contemplate them for the future.

## II. EARLY HISTORY

The origins of New Jersey hospital rate setting reach back to 1938, when, under the Blue Cross enabling legislation, the legislature gave the State Commissioner of Insurance and Banking the ability to review and regulate Blue Cross premiums and hospital payments. In 1962, the Commissioner established the first cap on payments to hospitals, a per diem limit<sup>6</sup> of fifty-six dollars.<sup>7</sup> Most hospitals were able to tolerate that ceiling. Because the ceiling applied only to Blue Cross charges,

---

by the patient or a third party. Two major types of uncompensated care often distinguished are "charity care" (the patient lacks sufficient resources to pay) and "bad debt" (sufficient resources or third party coverage are known to exist, but no payment is made). Usually an attempt must be made to collect amounts due before they can be classified as bad debt. This may be accomplished by referral to a collection agency.

5. See Social Security Amendments of 1983, Pub. L. 98-21, 97 Stat. 65 (1983) (codified at scattered sections of 42 U.S.C. (1990)).

6. A per diem limit is a limit on daily charges to patients, including room and board, nursing, lab tests, and other services.

7. Morone & Dunham, *The Waning of Professional Dominance: DRGs and the Hospitals*, 3 HEALTH AFFAIRS, Spring 1984, at 73.

hospitals could shift any excess costs to other paying patients. Thus, few of the state's hospitals found it necessary to negotiate rates above the limit, which entailed entering into an essentially pro forma process in which the hospital and Blue Cross went before a New Jersey Hospital Association (NJHA)<sup>8</sup> committee, negotiated a rate, and made a recommendation to the Commissioner of Insurance and Banking. The Commissioner, in turn, would virtually always accept the negotiated result.<sup>9</sup> While rate setting of some sort continued, it was neither contentious nor adversarial. Rather, it was a simple system based on self-regulation which received little, if any, public scrutiny.

This system was not a permanent solution. By 1968, medical inflation pushed costs for most hospitals in New Jersey over the fifty-six dollar per diem limit. In addition, what had been a cordial and brief negotiation had turned into a much more lengthy operation. One of the hospitals' main complaints, one which would be heard again and again over the next 20-odd years, was that the system had become "retrospective." That is, reviews of hospital per diem rates were occurring after the close of the fiscal year, so that the amount of revenue to which hospitals were entitled was not known until after the relevant year. Hospitals underscored the cash flow difficulties this caused when they were forced to pay vendors and borrow from banks with no clear idea of how much income they would eventually earn. Furthermore, there was an increasing backlog of hospital rate reviews.

Most significantly, inner-city hospitals complained of the lack of "case-mix adjustment," meaning that charges did not reflect the types of patients a hospital treated. Inner-city and teaching hospitals believed that they treated more complex, resource-intensive cases but were subject to the same ceilings and negotiations as other hospitals. Meanwhile, they had a smaller paying patient population to whom the unpaid costs of regulated Blue Cross patients or indigent cases could be shifted.

After two decades, certain themes emerged which would be repeated in later years: the effect of rate setting when only

---

8. The NJHA is a private industry association that represents most of the state's general hospitals and is extremely active in all hospital payment issues.

9. A. DUNHAM & J. MORONE, DRG EVALUATION, VOLUME IV-A: THE POLITICS OF INNOVATION (HEALTH RESEARCH AND EDUCATIONAL TRUST OF NEW JERSEY pub. 1983) [hereinafter DRG EVALUATION].

some payers are affected; the lack of timely rate setting decisions; calls for more refined methods of regulation to meet the needs of certain hospitals; and the evolving relationships among the regulators, hospitals, and payers. The first of these issues to surface was the balance of power between regulators and the industry. The other issues were left unresolved.

In the late 1960's, several events set the stage for more stringent government intervention. Blue Cross of New Jersey reported an operating deficit of thirteen million dollars in 1969 and began to seek tighter control over hospital capital expenditures<sup>10</sup> through a bolstered health planning process.<sup>11</sup> Hospitals accepted health planning as a way to keep out-of-state health providers from gaining any franchises in New Jersey. The hospitals reasoned that health planners were unlikely to allow major new investments in the state if there was already a generally adequate supply of health care services. Thus, both Blue Cross and the New Jersey Hospital Association lobbied for Certificate of Need legislation. The push for reform failed, however, over Blue Cross's concomitant demand for state-sponsored hospital budget review, which was something adamantly opposed by hospitals.

However, in the interim, a curious thing happened. NJHA helped to reform the old retrospective budget review process in response to payer concerns, enhancing the review process's potential for cost control. In 1968, it proposed and helped to implement a nonbinding, prospective peer review of hospital per diem rates. The Health Research and Education Trust (HRET)<sup>12</sup> of New Jersey conducted the review. The new system's prospectivity was an important development because it implied that hospitals would be required to live within a fixed and predetermined budget. If costs were poorly managed, there would be no automatic revenue increase to offset losses. However, the reviews were not truly prospective; a hospital could still come back for more. Nevertheless, NJHA had implemented the first prospective payment system in New

---

10. Capital expenditures include such expenses as buildings, land, and major equipment, as opposed to operating expenses such as salaries, food, and supplies.

11. The health planning process consisted of administrative regulation, backed by state and federal laws limiting availability of public funds to institutions given government approval (a "certificate of need") for new capital investments. Health planners authorize these investments if consistent with projected need, thus protecting against the unnecessary use of health care services simply to finance uncontrolled expansion.

12. The HRET is the research and educational arm of NJHA.

Jersey, no matter how piecemeal and primitive it might seem today.

### III. THE HEALTH CARE FACILITIES PLANNING ACT OF 1971

In 1971, a number of factors led to passage of the seminal New Jersey Health Care Facilities Planning Act.<sup>13</sup> Blue Cross was searching for more effective ways to control health costs in an atmosphere of public anxiety over medical inflation. Hospitals were seeking to strengthen their franchise rights by excluding new competitors from the state. The 1971 Act established both mandatory certificate of need health planning and hospital rate setting, following the example of New York, which had begun the first mandatory state rate regulation system one year earlier.<sup>14</sup> The Act placed the certificate of need program within the Department of Health and placed the power to regulate Blue Cross and Medicaid hospital payment rates with the Commissioner of Health as well.

This expanded governmental regulatory power was not a victory by Blue Cross or government over hospitals. By creating a mandatory planning procedure, the new law forced any entity wishing to compete with New Jersey's existing hospitals to document the need for expansion in the certificate of need process. The role of existing providers was strengthened, for example, by giving specific hospitals exclusive rights to start new services. The anticompetitiveness of the new law greatly benefitted hospitals.

Although the 1971 Act transferred budget review authority from HRET to the Department of Health, HRET continued to review hospital budgets. This came to an end after the 1974 publication of *Bureaucratic Malpractice* by a New Jersey public interest group.<sup>15</sup> Attacking the continued self-regulation of the hospital industry, despite the 1971 Health Care Facilities Planning Act, the report described how there had been "almost total erasure of a forward looking law that might have brought great public benefits."<sup>16</sup> Newly-elected Governor

---

13. Health Care Facilities Planning Act, 1971 N.J. LAWS, ch. 136, codified as amended at N.J. STAT. ANN. §§ 26:2H-1 through 2H-26 (1990).

14. Rosko, *The Impact of Prospective Payment: A Multidimensional Analysis of New Jersey's SHARE Program*, 9 J. HEALTH POLITICS, POLICY AND LAW 81 (1984).

15. R. POWELL, BUREAUCRATIC MALPRACTICE (1974) (this report was published by the Center for the Analysis of Public Issues).

16. *Id.*

Brendan Byrne and his Commissioner of Health, Joanne Finley, seized upon the report.

As a result of the external pressure, the Department of Health began to implement a rate regulation system as required by the 1971 Act. In 1975, the Department proposed an effective 2.5 percent rate increase, far below the double-digit rate increases that had been common before.<sup>17</sup> Several hospital lawsuits ensued, and these lawsuits, coupled with a Byrne administration weakened over a battle to introduce an income tax, eventually caused an average 12.5 percent rate increase for hospitals.

#### IV. SHARE: HARBINGER OF THE FUTURE

Nevertheless, change continued as the Standard Hospital Accounting and Rate Evaluation System (SHARE), a much more complex rate setting mechanism designed under the Department of Health's auspices, was put into place in 1976. SHARE consisted of a review by the Department of Health of costs by cost center<sup>18</sup> for hospitals which raised their rates over three percent. Rates were regulated only for Blue Cross and Medicaid. The two most striking features of SHARE were its complexity and its administrative intensity.

First, the genteel negotiation over rates by state and hospital analysts in front of NJHA or HRET was replaced by complicated cost accounting with government accountants and hearing officers.<sup>19</sup> Second, SHARE quickly became a lengthy process with numerous hospital administrative appeals. By 1978, the program had a one-year backlog of appeals. In 1979, there would be appeals dating back to 1975 still not heard. One-third of New Jersey's hospitals had not been issued their 1978 rates by May 1979.<sup>20</sup>

Once again, certain themes emerged. New Jersey was using an ever more complex and refined rate setting methodology to control costs. SHARE featured a more interventionist government role than did the systems of the 1950s and 1960s, but it produced the same backlogs. Under SHARE, however,

---

17. Morone & Dunham, *Slouching Toward National Health Insurance: The Unanticipated Politics of DRGs*, 62 BULL. N.Y. ACAD. MED. 646 (1986).

18. A cost center is a commonly defined area of hospital costs used for accounting purposes; examples are laboratory tests, radiology exams, and dietary (patient food).

19. Rosko, *supra* note 14.

20. DRG EVALUATION, *supra* note 9.

the issues of partial payer participation became more visible and a new problem emerged—uncompensated care. Three groups pressed for further regulatory change: urban hospitals, commercial payers, and government officials.

SHARE made no explicit provision for bad debt and charity care.<sup>21</sup> An inner-city hospital with a large indigent patient load was forced to make up any deficit due to care of those who could not pay by raising rates on other patients. But those rates could not be raised for SHARE-regulated payers—Blue Cross and Medicaid—leaving few patients to absorb the shift. By forcing and yet preventing such cost-shifting, SHARE placed urban hospitals in a double bind and demonstrated the problems inherent in regulating only some classes of payers.

Commercial payers also objected to SHARE, because they resented its *de facto* Blue Cross and Medicaid rate discount. As an effect of regulating rates for only these two payers, it was estimated that the two regulated payers were essentially receiving a 30 percent markdown on their payments.<sup>22</sup> This indicated that a more inclusive system was needed, one which would allow some sort of “equity” among payers.

The third pressure for further change, which echoed historical developments, was the interest of government officials in refining the rate setting methodology. Commissioner Finley was eager to experiment with a case-mix (sensitive per case) payment system which she believed could change the incentives inherent in a per diem reimbursement system. Per diem payment was unfair because it paid every hospital the same daily amount without regard to the type of patient treated and because it encouraged overuse of services since each additional day of hospital stay generated revenue for the hospital.

In contrast, an adjustment for case mix helped hospitals treating sicker patients, and per case payments encouraged hospitals to manage each patient’s care more efficiently because no additional revenue would be forthcoming for each additional day of hospital stay. Finley had become familiar with the possibilities of per case reimbursement while on the faculty at Yale University, where a group of researchers had been developing a patient classification system known as Diagnosis Related Groups or DRGs.<sup>23</sup> Such a system would be pro-

---

21. *Id.*

22. *Id.*

23. DRGs are clusters of cases within the same diagnostic category (e.g.,

spective in that the payment for a given hospitalization would be set before, not after, the services were delivered. The federal government had also expressed interest in funding a demonstration project using a case-mix sensitive payment scheme because it would be easier to put in place a system for controlling federal hospital care costs through Medicare if the objections of hospitals treating sicker patients were addressed.

Eager to provide such a demonstration and to bring about some sort of "payer equity," the Department of Health helped craft a piece of legislation, S-1454. The bill would have extended rate setting over all payers and would have allowed a reimbursement demonstration. It also would have forced pooling of the state's hospital endowments under state control. With no hospital support, with Blue Cross opposition to the perceived loss of their effective discount relative to other payers, and with Governor Brendan Byrne in deep political trouble, the bill died in committee in 1976.<sup>24</sup>

After Governor Byrne's re-election,<sup>25</sup> S-1454 was rewritten as S-446. Any reference to control over hospital endowments was dropped, thus mollifying hospitals.<sup>26</sup> Oblique language about a case-mix reimbursement system remained but with no mention of DRGs, which remained an abstract and esoteric concept.<sup>27</sup>

However, the most important change had nothing to do with case-mix reimbursement. The legislation included an explicit reference to the cost of uncompensated care as an allowable "financial element."<sup>28</sup> This change earned the support of New Jersey's struggling urban hospitals, battered by the SHARE system and indigent case loads. Under the bill, they could charge every patient the same amount, and that

---

respiratory system) that consume similar resources. Once cases are classified into DRGs, it is relatively easy to develop an average fixed payment rate for each case, depending on the cost of resources used to treat like cases in the DRG. DRG rates are therefore based on case mix and are fixed per case.

24. DRG EVALUATION, *supra* note 9.

25. Byrne had been expected to lose re-election. The NJHA vigorously and publicly opposed his re-election. May & Wasserman, *Selected Results from an Evaluation of the New Jersey Diagnosis-Related Group System*, 19 HEALTH SERVICES RESEARCH 547 (1984). Despite every prediction to the contrary, Byrne was returned to office and proceeded to retain his entire cabinet.

26. DRG EVALUATION, *supra* note 9.

27. Act effective July 20, 1978, ch. 83, 1978 N.J. LAWS, (codified at N.J. STAT. ANN. § 17:48-7 (Supp. 1990) and at scattered sections of N.J. STAT. ANN. § 26:2H (Supp. 1990)).

28. *Id.*



amount would include all the costs of charity care and bad debt incurred in the operations of that institution. Recognition of uncompensated care forced NJHA to support the bill's expansion of rate setting authority because S-446 threatened to cause a split in the ranks of NJHA should the association try to oppose the legislation. Urban hospitals would conceivably oppose NJHA and might even break away to form their own association, as they indeed threatened to do on several occasions.<sup>29</sup> NJHA opposition to the bill had been effectively neutralized by this change.

There were, of course, other factors that led to the eventual passage of S-446. First, the federal government, interested in a demonstration, promised a waiver of Medicare reimbursement rules in return for the opportunity to explore the effects of case-mix adjusted reimbursement. Thus, Medicare would pay New Jersey hospitals under New Jersey rates, including the "financial element" of uncompensated care, which would represent an infusion of sixty million dollars of new money annually.<sup>30</sup> However, the federal government imposed conditions on the waiver, including cost neutrality or savings to Medicare. These conditions proved harder than expected to meet, and only a fraction of the promised infusion ever materialized. Nevertheless, the promise of sixty million dollars was a major inducement to hospitals and legislators when passing the bill.

A further inducement was that S-446 vaguely assured the "solvency" of "efficient and well-utilized" hospitals.<sup>31</sup> While no one knows to this day what those terms mean, the reference to solvency at least gives hospitals some basis for claiming that their financial health is guaranteed by state law. Another element of the deal over S-446 helped Blue Cross, which was upset over its loss of its de facto discount. To compensate, Blue Cross was allowed to extend experience rating<sup>32</sup> to groups of 50 to 100 subscribers, whereas experience rating had been allowed only for groups numbering over 100 previously.

---

29. Morone & Dunham, *supra* note 17.

30. DRG EVALUATION, *supra* note 9.

31. 1978 N.J. LAWS, ch. 83 (codified at N.J. STAT. ANN. § 17:48-7 and at scattered sections of N.J. STAT. ANN. 26:2H).

32. "Experience rating" means setting premiums for a group based on its record of health care costs and its characteristics that might affect future costs (e.g., age). The alternative, community rating, spreads costs over a broader base and is often perceived as fairer by consumer advocates. Payers often prefer experience rating because it allows more competitive pricing to lower cost groups.

S-446 passed after lengthy hearings and negotiations in 1978.<sup>33</sup> Despite the subsequent second thoughts of many legislators who had no idea that a statutory reference to "case-mix" would be translated into dozens of pages of regulations<sup>34</sup> creating an alien and complicated system called DRGs, the first 25 hospitals came on line in the new reimbursement system in 1980. While space does not permit a fuller explanation, let it suffice to say that the technical problems of implementation in the face of some industry reluctance were considerable. Implementation required the creation of hundreds of patient and hospitalization rates at each of over 100 hospitals. This was not a simple task. Nonetheless, by 1982, all New Jersey hospitals were phased into the DRG system. Remarkably, while some expected that the 1981 election of new Republican Governor Thomas Kean would sound the death knell of government intervention in the form of DRGs, little actually happened. Indeed, with the urban hospital issue in mind, the NJHA passed a resolution asking the new chief executive to continue the experiment.<sup>35</sup>

The passage and implementation of S-446 pointed to several forces and trends that would have critical ramifications for later years. The system created incentives for cost control by setting per-case rates, prospectively based on case mix (in this case, DRGs). Hospitals accepted rate regulation in return for certain forms of protection, such as health planning which kept their franchises intact. The uncompensated care issue was important enough to possibly undermine and divide the hospital association. The key to addressing uncompensated care was to have all payers, including Medicare, in the same system. If the system had one shortcoming, it was its complexity. Hospitals and payers understood the system's virtues and accepted complexity as the price to be paid, but consumers had a harder time doing so.

#### IV. EARLY DAYS OF DRGS

From the beginning, the newly instituted DRG component of New Jersey's system, while less critical in retrospect than the system's recognition of uncompensated care, suffered from

---

33. 1978 N.J. LAWS, ch. 83 (codified at N.J. STAT. ANN. § 17:48-7 and at scattered sections of N.J. STAT. ANN. 26:2H).

34. N.J. ADMIN. CODE tit. 8:31B, § § 2.1-5.3 (1989).

35. DRG EVALUATION, *supra* note 9.

poor public relations. These problems continue periodically to this day. One typical scandal involved the "6,000 dollar broken finger." A patient with a finger fracture would end up in the same DRG as total hip replacements. Unfortunately, the DRG patient classifications often lumped dissimilar patients together. Although the diagnosis group classifications can be refined through experience, cases in which hospitals were overcompensated were seized upon by the public and the legislature. Indeed, such classification problems are some of the few elements of New Jersey's complex rate setting system which the lay person can easily understand. The inner workings of the DRG system are so difficult to explain (no one has ever tried to do so in a comprehensive fashion publicly as far as we can tell) that they pose a public relations problem in and of themselves. Objections to the complexity and inaccessibility of the system surfaced, as they would again ten years later in another time of stress.

How did the system prevail throughout the 1980's in the face of public misperceptions? The answer is that it met the goals of hospitals and payers well enough and attained its own goals sufficiently to offset criticism by the public. There is good evidence that DRG reimbursement led to a dramatic improvement in the financial position of virtually all New Jersey hospitals,<sup>36</sup> with urban hospitals benefitting the most.<sup>37</sup> Case-mix prospective payment brought with it a lot of cash, especially through the newly authorized uncompensated care element. While a few hospitals opposed the new system, some of the largest hospitals were clearly beneficiaries. Any attempt on the part of NJHA to replace or remove DRGs would have been a perceived threat to the fiscal solvency of many of its biggest members. NJHA was thus forced to keep a low profile on the issue lest it find itself split asunder.

Despite the added cost of the uncompensated care provisions, at least one class of payers reaped an important benefit. Commercial insurers had operated at a distinct disadvantage under SHARE. They, in essence, paid for the alleged 30 per-

---

36. Hadley & Swartz, *The Impacts on Hospital Costs Between 1980 and 1984 of Hospital Rate Regulation, Competition, and Changes in Health Insurance Coverage*, 26 INQUIRY, Spring 1989, at 35.

37. Hsiao & Dunn, *The Impact of DRG Payment on New Jersey Hospitals*, 24 INQUIRY, Fall 1987, at 212.

cent discount of Blue Cross and Medicaid.<sup>38</sup> Payer equity under the new system was important to commercial insurers, and commercial insurers (including Prudential, which is based in New Jersey) were important to the state.<sup>39</sup> They thus saw the all-payer system as a major boon.

New Jersey's system became nationally known for its use of DRGs and the incentives for hospital cost control that per-case, case-mix adjusted payments were expected to have. Yet, while the per case method of payment was important in terms of the new incentives it created, it was not DRGs that formed the real pressure point on the system. One can imagine many different payment schemes, but equity among payers and the recognition of bad debt and charity care remain as the forces underlying the New Jersey system. Without a solution to the problems of payers, especially an end to large scale cost-shifting between classes of payers, there could be no equitable solution to the problems of bad debt and charity care. The failure of the all-payer coalition could, in turn, help destroy the uncompensated care mechanism. These were the two elements around which debate would revolve in the future.

#### A. *Evaluating the Effects of the System*

The cost containment effects of DRG reimbursement in its early years in New Jersey are difficult to quantify.<sup>40</sup> One study of Maryland and New Jersey reimbursement found that rate regulation by itself led to a nine percent increase in total hospital costs in 1980, no significant change in 1981-83, and costs that were 10.9 percent lower by 1984 (all relative to 1979). This conclusion was consonant with the finding that government rate regulation, in general, was effective on both the federal and state levels in containing hospital costs.<sup>41</sup> However, another study of the New Jersey experience found that any decrease in cost per case was offset by a small but measurable increase in admission rates after the introduction of DRGs.<sup>42</sup> Overall, one could contend that hospitals reacted rationally,

---

38. This discount has not been conclusively documented, and the 30 percent figure is based on the memory of former state and insurance company officials.

39. Prudential and other commercial insurers are significant employers and a major economic force in New Jersey.

40. The statistical methodology in any such evaluation would be open to debate.

41. Hadley & Swartz, *supra* note 36.

42. Hsiao & Dunn, *supra* note 37.

cutting their costs per case but increasing their reimbursement by increasing the number of admissions.

The effects of DRG reimbursement on quality of care are even less clear than the cost-containment effects of DRGs. One study found that length of stay, daily use of radiologic procedures, and volume of radiologic procedures per patient declined under DRG prospective reimbursement in New Jersey, while the volume of laboratory services per day and per case increased.<sup>43</sup> The effects this has had on quality of care are simply not known, especially when one realizes that the "right" volume of these procedures is unknown. Patients may have received too many tests and procedures before DRGs, and now receive too few. Alternatively, patients may have previously received too few, and now receive too many. All hypotheses are equally plausible without a rigorous analysis of quantifiable patient outcomes. Unfortunately, no such analysis was undertaken in New Jersey before or after 1980, and quality of care continues to be an area of comparative neglect in the state's prospective payment system.<sup>44</sup> Moreover, it again received little mention in the next era of reform ten years after the system's inception.

### B. Problems Emerge

The years following the full enactment of the DRG system in New Jersey saw several key developments with ominous consequences for the future. In one sense, the experiment slowly became a victim of its own success. The federal Health Care Financing Administration (HCFA)<sup>45</sup> liked what it saw in its New Jersey demonstration. Faced with an average yearly Medicare hospital spending increase of 19.2 percent from 1967 through 1982, HCFA moved quickly to adopt a new Prospective Payment System (PPS) for Medicare. Congress ordered HCFA to design a hospital payment reform in September 1982.<sup>46</sup> Thirteen months later, PPS was up and running.<sup>47</sup>

---

43. Broyles, *Efficiency, Costs, and Quality: The New Jersey Experience Revisited*, 27 *INQUIRY*, Spring 1990, at 86.

44. The state has never really performed an evaluation.

45. The HCFA is the component of the federal Department of Health and Human Services which operates Medicare and Medicaid.

46. Tax Equity and Fiscal Responsibility Act of 1982, Title I, Pub. L. 97-248, 96 Stat. 324 (1982) (codified at scattered sections of 42 U.S.C. (1990)).

47. See Social Security Amendments of 1983, Pub. L. 98-21, 97 Stat. 65 (1983) (codified at scattered sections of 42 U.S.C. (1990)) (which created Medicare's Prospective Payment System for Inpatient Hospitals). Medicare's system is like New

The adoption of PPS by Medicare set the stage for that program's withdrawal from the New Jersey all-payer system—a most significant development since Medicare accounts for thirty-nine percent of the average New Jersey hospital's business. PPS gave the federal government the ability to adjust hospital payments on the basis of budget constraints, an ability it had never before possessed. Not only did the federal government gain the cost control incentives of per-case payment, but the annual decision of how much to increase rates was left initially to the federal Executive Branch at a time of record federal deficits. The benefits now accrued to the United States government, not to the New Jersey rate-setting system. As PPS rates declined relative to New Jersey rates, it became harder and harder to satisfy the cost neutrality or savings requirements of the federal waiver. Gradually, beginning in 1986, it became necessary for a share of Medicare's payments for uncompensated care under New Jersey's system to be picked up by other payers.<sup>48</sup> Medicare, under the waiver, had been paying its share of the approved cost of uncompensated care of non-Medicare patients in New Jersey, something it does not do in other states. The all-payer system was threatened by the explicit reintroduction of cost-shifting for the first time since 1980, undermining the consensus that had grown up around bad debt and charity care.

Closely linked to Medicare's withdrawal from New Jersey's system was the problem of uncompensated care. S-446 had recognized bad debt and charity care as approved costs of doing business. Each hospital had its rates increased enough to recoup its own uncompensated care costs, causing the development of large rate differences among hospitals.<sup>49</sup> These rate variations resulted in a major inequity among hospitals which was exacerbated as payers (especially health maintenance organizations) became more price conscious and began to shop among hospitals for the best price. In 1985, some hospitals raised their rates by as little as one percent for uncompensated

---

Jersey's system in most important respects. Both classify patients into DRGs and set a fixed price for each case. The federal Medicare system does not allow payment for uncompensated care and does not include mandatory health planning through Certificate of Need, which was repealed by Congress just as PPS was created.

48. Interview with Nancy L. Featherstone, New Jersey Department of Health (Jan. 7, 1991).

49. Crawford, *All-Payer Financing of Uncompensated Care: The New Jersey Experience*, 62 BULL. N.Y. ACAD. MED. 630 (1986).

care while others raised theirs by as much as twenty-five percent.<sup>50</sup> Hospitals with large indigent care loads were placed at a competitive disadvantage because their rates had to be that much higher. This led to their loss of insured patients as insurers sought to have their subscribers admitted to lower cost hospitals, eroding patient base and causing these hospitals to further raise their uncompensated care mark-ups.

New Jersey's answer to this problem, adopted in 1986, was the Uncompensated Care Trust Fund.<sup>51</sup> Every hospital would have the same percentage added on to its bills for uncompensated care. Those hospitals which collected more than their costs from the add-on because of their low uncompensated care burden would pay the excess into the Fund. Those who did not collect enough would draw from the Fund.<sup>52</sup> Thus, the total cost of uncompensated care did not change because of the Fund, but the collection method was altered to allow for uniform uncompensated care add-ons across the state.

The formation of the Uncompensated Care Trust Fund had several unintended consequences. The most important was that it made uncompensated care a much more visible and explosive issue because its authorizing legislation included a sunset clause, setting an expiration date for the Fund. From then on a major element of hospital rate setting and of providing care to the indigent would be periodically debated in the legislature, something which the structure of the original rate setting legislation had avoided by placing most of the details in regulation, not legislation.<sup>53</sup> From then on, the legislature and the public saw a single identifiable fund, financed through an increase to each hospital bill which was in turn financed by insurance premiums.

Other reforms and refinements to New Jersey's rate setting system were added to New Jersey regulations in 1988 and 1989.<sup>54</sup> Reimbursement was made much more dependent on hospital volume, with the intention that hospitals with declining patient loads would be slowly "squeezed out" of the system

---

50. *Id.*

51. Uncompensated Care Trust Fund Act, ch. 204, 1986 N.J. LAWS, (originally codified at N.J. STAT. ANN. § 26:2H-4.1 (Supp. 1990), continued by N.J. STAT. ANN. § 26:2H-18.4 and § 26:2H-18.23 (Supp. 1990), expired on Dec. 31, 1990, by Act approved Jan. 1, 1989, ch. 1, 1989 N.J. LAWS § 23).

52. N.J. ADMIN. CODE tit. 8:31B, § § 7.1-7.9 (1989).

53. *Id.*

54. *Id.*

as their revenues declined. Reimbursement of overhead costs was also altered to reward hospitals with increasing volume. An attempt was made at further refinement of the DRG system to recognize the severity of an individual patient's illness and to adjust the payment rate concomitantly, but this later foundered in the face of payer opposition, hospital division, and the inertia of a lame duck Administration. Meanwhile, the issues of the uninsured, of the failing all-payer system, and of overall medical inflation remained.

#### V. THE 1990'S OPEN: OLD PROBLEMS, NEW SOLUTIONS

The debate over further technical refinements to New Jersey's DRG system in 1988 and 1989 left unresolved more fundamental issues of cost and access which once again emerged as a new governor took office in 1990. These issues echoed not only the debate taking place at a national level, but reflected the same problems which had prompted the creation of the DRG system twelve years before: increasing health care costs, especially for uncompensated care; the problem of financial stability of Blue Cross/Blue Shield; and the growing backlog of unresolved issues in a complex rate setting system. Further, the emphasis of the uncompensated care debate shifted. The focus was no longer solely on the solvency of hospitals but expanded to examine barriers to access to care for one million uninsured New Jerseyans.

The Uncompensated Care Trust Fund might have remained visible, though not explosive, had it not been for several concurrent trends. First, the uncompensated care price tag has been rising rapidly, rising from 239 million dollars in 1983 to over 700 million dollars in 1990 and to a projected 912 million dollars in 1991.<sup>55</sup> Growth may have been due to number of factors including medical price inflation and more uninsured individuals, but whatever the reason, it grew rapidly as a proportion of total hospital revenue, from slightly over six percent in 1983 to almost ten percent by the close of the decade.<sup>56</sup> Here was a giant fund, growing rapidly, and under the control of the state legislature. It made a visible target for those both within and without government who saw the Fund as a manifestation of unrestrained health care expense.

---

55. Uncompensated Care Trust Fund Calculation, New Jersey Dept. of Health (Jan. 1, 1991) (copy on file at the University of Puget Sound Law Review).

56. *Id.*



While the Fund undoubtedly achieved its goal of assuring access and more equitably distributing the costs of uncompensated care among New Jersey hospitals, the surcharge required to do so added approximately eighteen percent to the average non-Medicare hospital bill in 1989.<sup>57</sup> The Trust Fund was growing twice as fast as the overall cost of hospital care.<sup>58</sup> Furthermore, with the end of the waiver in 1988, Medicare no longer paid for uncompensated care, making the effective surcharge for participating payers even higher. In effect, half the patients were financing the entire cost of uncompensated care.<sup>59</sup> Accordingly, the size of the Trust Fund and the use of a surcharge on hospital bills to finance uncompensated care became increasingly controversial issues.

By 1990, the number of uninsured New Jerseyans approached one million.<sup>60</sup> As in the rest of the nation, several factors contributed to the rapid growth in the number of uninsured in New Jersey, such as growth in the historically underinsured small business sector and reductions in dependent coverage. Two-thirds of uninsured New Jerseyans were employed or dependents of workers, and a disproportionate number worked in small businesses. One in four were children.<sup>61</sup> Growth in the number of uninsured increased the uncompensated care burden faced by hospitals and the two issues became linked.

Another shortcoming of the Uncompensated Care Trust Fund became apparent as the problems of the uninsured received more attention on a national level. The Trust Fund did indeed see to it that a hospital got paid for treating all its patients, as long as the hospital made a good faith effort to collect from all patients who were deemed ineligible for charity care. However, this was not the same as providing insurance to the uninsured. Patients without insurance still faced collection efforts if they were not eligible for charity care but, nonetheless, were too poor to pay a hospital bill. More profoundly, there was no entitlement to care for uninsured individuals, such as an insurance plan might provide.

---

57. GOVERNOR'S COMM. ON HEALTH CARE COSTS, COST ACCESSIBILITY RESPONSIBILITY EFFICIENCY FOR NEW JERSEY 4 (1990) [hereinafter CARE] (copy on file with the University of Puget Sound Law Review).

58. Uncompensated Care Trust Fund Calculation, *supra* note 55.

59. See CARE, *supra* note 57, at 42.

60. See CARE, *supra* note 57, at 6.

61. Current Population Survey, U.S. Bureau of the Census (March 1986).

The rising costs of health care in general, and uncompensated care in particular, had taken their toll on Blue Cross by 1990. The "Blues" market share declined markedly, and state insurance regulators were asked to approve rate increases for individual and small group plans, the most economically vulnerable plans, of forty-seven percent in 1990. This followed increases of twenty-two percent in 1988 and twenty-four percent in 1989.<sup>62</sup> Blue Cross maintained that cost increases of this magnitude were required by the "hidden tax" on each bill collected to finance uncompensated care.<sup>63</sup> Because health care in New Jersey is subject to the same cost pressures occurring nationally, the "hidden tax" argument may not have been completely supported by the facts, but it was a politically appealing argument.

Finally, the complexity of the state's rate setting system had resulted in a logjam of as many as six years' unresolved rate appeals and final reconciliations.<sup>64</sup> The system was viewed by hospitals, payers and patients alike as burdensome and unmanageable. What had begun as a special exceptions process to respond to extraordinary cost increases at individual hospitals had burgeoned into as many as 2,000 annual rate appeals filed by New Jersey's 85 general hospitals.<sup>65</sup> The state Department of Health was also swamped by complaints from patients because the charges they saw on hospital bills were often vastly exceeded by the mysterious "DRG" amount, including markup factors for uncompensated care, Medicare shortfalls, and the like. In addition, the complexity and confusion of the system failed to yield clear benefits. New Jersey hospitals' cost growth approached national rates, and payers faced continual uncertainty about hospital costs because DRG rates swung widely each month with retrospective rate adjustments.<sup>66</sup> The more special adjustments that were made, the more uncertainty that was created for payers trying to set premiums and for hospitals trying to close their books. Thus, the issues of the 1960s and early 1980s were re-visited as the 1990s began.

Responding to these pressures, newly elected Governor James Florio, in April 1990, appointed a Commission on Health

---

62. New Jersey Blue Cross/Blue Shield testimony before N.J. Governor's Commission on Health Care Costs, June 12, 1990.

63. *Id.*

64. See CARE, *supra* note 57.

65. See CARE, *supra* note 57, at 6.

66. *Id.* at 23-26.

Care Costs to examine the components of New Jersey's health care system as they related to cost and access. The Commission's members held open hearings and reviewed reports from hospitals, payers, business, and state agencies, as well as studying approaches taken by other states. Working in five task forces, by October 1990 the Commission had formulated a broad approach, encompassing ninety-two specific recommendations for reforming New Jersey's health care system.<sup>67</sup> Most dealt with changes in uncompensated care financing, rate setting, health planning, and Medicaid. The remainder of this Article outlines the Commission's most significant recommendations and evaluates the chances for success and the likely price of failure.

## VI. HOW TO PAY FOR THE UNINSURED

The rising costs of health care for business and the growing problem of the uninsured made the future of the Uncompensated Care Trust Fund the most urgent business of the Commission. The "hidden tax" on hospital bills, once the linchpin of success for New Jersey rate setting, was becoming far too large to hide, and the Trust Fund's authorizing legislation was scheduled to expire in December 1990. It was no longer enough to argue that the Trust Fund's growth was evidence that New Jerseyans enjoyed access to hospital care regardless of insurance status. Nor could it be argued that the Trust Fund merely made visible the subsidy of costs which were recognized in other states through unregulated cost shifting.

From the beginning, Commission members, the governor, and key legislators remained committed to financing care for the uninsured.<sup>68</sup> The imperatives against threatening access to care for the uninsured and urban hospital insolvency were just too strong. Thus, the Commission focused primarily on reforming the financing of uncompensated care. There was consensus that the surcharge approach was unfair to businesses that did provide health insurance, taxing them to pay for their own employees as well as for their own (and Medicare's) share of the uninsured.<sup>69</sup> Business claimed it was put at a competitive disadvantage when compared with competitors in

---

67. *Id.* at 2.

68. *Id.* at 1.

69. *Id.* at 45.

other states who were not subsidizing uncompensated care. However, others maintained that the only difference in New Jersey was that this subsidy was visible in the Uncompensated Care Trust Fund. Business demanded relief from a relentless spiral: rising costs made health insurance less affordable, led to fewer people with insurance, led to more uncompensated care, drove up bills for the remaining insured, and made their insurance less affordable. As noted earlier, Blue Cross blamed massive premium increases on the surcharge method for financing uncompensated care. Whether this is true or not, it set the stage for Blue Cross to argue for alternate financing as a precondition for their continued willingness to participate in rate setting (recall that Blue Cross received larger discounts before the all-payer system).

The Commission's deliberations also revealed doubts about whether the continued guarantee of uncompensated care payments to hospitals was the best use of resources. The Commission noted that the Trust Fund made access to health care for the uninsured available only in the hospital, instead of subsidizing primary and preventive care in community based settings which could be more cost-effective and improve continuity of care.<sup>70</sup> This also underscored charges that the Uncompensated Care Trust Fund was designed to assure hospital solvency, not to guarantee people the care they need regardless of ability to pay. Some skeptics emphasized that over eighty percent of Trust Fund payments in 1989 covered uncollectible bad debts, while only twenty percent went to pay for care of individuals meeting the state's charity care guidelines.<sup>71</sup> This characterization is somewhat unfair because a good portion of so-called bad debt is probably attributable to individuals who actually meet charity care guidelines. The criticism does, however, underscore the fact that the amount of "true" charity care is unknown.

Faced with these arguments, the Commission recommended two fundamental changes in strategy: the adoption of a broad-based financing approach for uncompensated care and the restructuring of the market for insurance by converting the Trust Fund from a simple payer of bills to a true insurance mechanism that would expand access to health insurance. To implement its broad-based financing approach, the Commission

---

70. *Id.*

71. *Id.* at 49.

endorsed abolition of the surcharge on hospital bills and the substitution of a one percent payroll tax on the first 14,400 dollars of income coupled with "pay or play" penalties on employers of 1,000 dollars for every employee not provided with health coverage.<sup>72</sup> With the payroll tax instead of the surcharge, Commission members argued that the costs of health insurance to some New Jersey businesses could actually decline.<sup>73</sup> Under the payroll tax plan, employers who do provide insurance to their employees would pay, on average, 144 dollars in taxes to finance uncompensated care instead of 200 dollars in insurance premiums, a savings of fifty-six dollars per employee over the "hidden tax" approach.<sup>74</sup>

Adoption of a broader financing mechanism would also make possible the second feature of this strategy: reducing the amount of uncompensated care by increasing access to health insurance. The Trust Fund would be replaced in part by publicly sponsored health insurance plans which could offer innovative, low-cost insurance subsidized by the new payroll tax and revenue from employer penalties. Such plans could stress primary and preventive care, could pay for care in the most appropriate setting, and could apply the managed care principles used with success in other states. The design of primary and preventive care programs for children, documented as cost-effective,<sup>75</sup> would be a priority. This structural reform would be coupled with other changes meant to improve access to insurance, such as prohibiting pre-existing condition coverage exclusion, relaxing some insurance mandates and requiring community rating for individual and small group policies.<sup>76</sup>

Not incidentally, this restructuring could also resolve Blue Cross's grim financial problems. The Commission recommended splitting Blue Cross into two entities—one retaining its stable large group business, and the other a public purpose entity eligible for subsidies for the uninsured or underinsured that would be required to use community rating.<sup>77</sup> While subsidies would be available for any insurer offering the low-cost plans described above, this strategy at least assured that public

---

72. *Id.* at 48.

73. *Id.*

74. *Id.* at 39-40.

75. UNITED STATES PREVENTIVE SERVICES TASK FORCE, GUIDE TO CLINICAL PREVENTIVE SERVICES (1989).

76. See CARE, *supra* note 57, at 34.

77. *Id.*

revenues would be available to continue supporting Blue Cross as "insurer of last resort" should no other plans step forward.

As 1990 drew to a close, the Commission's recommendations ran into political roadblocks as uncompensated care took center stage in a bigger, more political arena. The payroll tax—key to the new strategy for access to health care—faced little chance of success in the face of taxpayer reaction to the governor's program of income and excise tax increases adopted earlier in the year. Key legislators refused to extend the Trust Fund until a consensus emerged on reforming the broader system of financing health care. Governor Florio agreed that a simple extension of the Trust Fund would be undesirable unless coupled with other initiatives broadening access to health care and controlling costs. As required by law, once the Trust Fund expired on December 31, 1990, the New Jersey Department of Health reintroduced the system of paying for uncompensated care that had existed before the Trust Fund's creation in 1986, under which each hospital was allowed to mark up its bills sufficiently to collect uncompensated care from its own paying patients. But five years later, with hospital costs much higher and Medicare no longer paying its share of uncompensated care, there was real fear that such a system could push hospital bills to unsustainable levels. The surcharge for some inner city hospitals would run as high as 60 percent, and some hospitals worried aloud that their few insured patients would be driven away, forcing insolvency.<sup>78</sup>

Expiration of the Trust Fund in December 1990 may or may not have forced a public health crisis. The larger question is whether the expiration has provided the momentum necessary to move forward on a strategy for improving access to health insurance. Adoption of a payroll tax seems next to impossible, certainly until after the November 1991 elections. Yet without a source of financing to replace the surcharge, the recommendations of the Governor's Commission are far harder to put in place.

## VII. THE FUTURE OF HEALTH CARE COST CONTROL

Recognizing that the largest sources of cost growth in the 1990s are not in the hospital but in outpatient diagnosis and treatment, the Commission essentially accepted health plan-

---

78. As of April 1991, these problems remain, and the Fund has not been revived.

ning principles that new investments should be allowed only where an objective determination of need was made. The Commission recommended that the need for *all* health facilities and services, not only hospital facilities and services, be assessed in light of a state Health Plan with the force and effect of state law. Such a plan would explicitly declare where new services and facilities could be developed in New Jersey. The current health planning statutes clearly exclude the private practice of medicine from regulation.<sup>79</sup> This has been a major issue of contention for hospitals claiming that they are forced to compete on an uneven playing field. Extending the certificate of need process beyond hospitals to other providers of outpatient diagnosis and treatment, including physician-owned providers, would recognize that hospital regulation addressed a shrinking portion of the diversifying market for health care. For example, in 1990 it was estimated that there were perhaps eight magnetic resonance imagers in New Jersey hospitals but over sixty in the possession of unregulated physician practices.<sup>80</sup> The effects of regulating only part of the "pie" were obvious. Indeed, extension of such regulation can be seen as one way of helping to protect the hospital franchise on certain services which is increasingly threatened by the movement of new technologies to physician offices.<sup>81</sup>

It is interesting to note, however, that the Commission did not repeat the pattern set in S-446 of regulating supply through health planning and regulating reimbursement. The Commission did not make recommendations to regulate reimbursement for outpatient services outside those owned by the hospital. Nonetheless, the laudable decision to extend regulation to other settings, if only partially, must be viewed as an extension of the traditional quid pro quo with payers asked to subsidize uncompensated care. If health plans created for the uninsured were to be restructured to cover non-hospital services, then payers must be assured that the cost of these services be restrained through rigorous needs assessment. It is safe to assume that rate regulation of providers not owned by hospitals will be next.

Endorsement of the State Health Plan approach also reflected the Commission's resolve to put new "teeth" in the

---

79. N.J. STAT. ANN. § 26:2H-2(a) & (b) (1990).

80. Uncompensated Care Trust Fund Calculation, *supra* note 55.

81. Such protection can control costs but can also stifle innovation.

hospital regulatory process. There was a perception in the course of the Commission's hearings that the health planning infrastructure served to give franchises to hospitals without due regard to quantifiable need or cost. Under the Commission's recommendations, regulators would have powerful tools: a plan identifying clearly where excess capacity existed and the ability to closely monitor new hospital performance benchmarks, which will identify high cost, inefficient, or insolvent New Jersey hospitals relative to national norms. The notion is that regulators will use these new tools to improve financial and utilization problems at troubled hospitals if the capacity is truly needed, while making a clearer case for closing or merging unneeded hospitals. Once again, the Commission's recommendations will only be as good as the political will and leadership devoted to implementing them. Closing hospitals or denying certificates of need, for example, are often very sensitive politically.

Another focus of the Commission's recommendations was rate regulation of capital costs, which had traditionally been less closely monitored than operating costs. The Commission made its health planning recommendations at a time when New Jersey's hospitals faced record debt burdens and when their traditionally high bond ratings had slowly slipped. The Commission called for imposition of a statewide annual dollar cap on capital projects, so that all requests for financing could be judged in the context of a limited pool of financing. This potentially explosive feature was left until 1992 to develop and will be controversial because hospitals will be forced to compete for limited opportunity to rebuild or expand. Another Commission recommendation, allocation of capital expenditures in an all-inclusive DRG rate, is unlikely to be implemented in the near term. Rather, New Jersey seems likely to wait for the outcome of the federal government's latest attempt to similarly modify the Medicare program.

A final controversial feature of the Commission's report was the recommendation to "rebundle" reimbursement for hospital-based specialists into hospital rates.<sup>82</sup> Separate billing for these services had originally been allowed to comply with Medicare regulations, but it was clear that in the process incentives for cost control had been lost.<sup>83</sup> The Commission bravely

---

82. CARE, *supra* note 57, at 26.

83. *Id.*



proposed folding payment for these specialists' services into the DRG rate for non-Medicare patients to align the incentives of physicians and hospitals toward reducing volume and intensity.<sup>84</sup> This recommendation will likely generate fierce debate. Hospitals are already balking at the prospect of being forced to regulate their own specialists under a DRG rate instead of allowing the specialists to bill separately. The involved physicians are preparing to fight any threats to their professional autonomy. On balance, rebundling seems an unlikely prospect for the short term. There will be only so many recommendations on which the physician community can be successfully fought, and it appears that extending the health planning process to non-hospital settings is viewed as a higher priority by Commission members.

The Commission's recommendations are as remarkable for what they do not address as for what they do. Its report focuses on a few key steps: extension of health planning to all providers, measuring hospital performance against need, capping capital expenditures, and rebundling physicians. These steps will face formidable political opposition, but they also stand the best chance of addressing the underlying dynamics of health care cost growth in the 1990s. The Commission did not put as much emphasis on the mechanics of regulating hospital rates.

One remarkable aspect of the Commission's recommendations, for example, was the absence of any real debate on whether to maintain state regulation of hospital costs on the basis of DRGs. Such an outcome is surprising, since the Commission began its deliberations amid speculation about the system's effectiveness and listened for weeks to a drumbeat of complaints about the DRG system's complexity and confusion. In the end, however, this underlying foundation of rate setting in New Jersey, developed over a decade ago, was left undisturbed.<sup>85</sup> Cost control through rate regulation, no matter its faults, was a necessary price to be paid. Insurers and business agreed to finance uncompensated care because they were assured of some measure of fiscal restraint. Hospitals agreed to rate regulation because they were assured of payment for uncompensated care and, some argued, sheltered from competition.

---

84. *Id.*

85. *See generally id.* at 23-26.

The Commission also made a number of relatively technical and less critical recommendations for refinements in hospital reimbursement that are sure to generate the expected distributional fights in the months to come. Two notable refinements were recommendations on how to make reimbursement for overhead costs more sensitive to the types of cases a hospital treats and how to institute a payment adjustment that better recognizes the severity of illness of the patients a hospital treats. As before, these technical refinements are unlikely to be central to the program's future. Also, the Commission recommended simplifying the reimbursement system by abolishing most rate appeals and retrospective rate adjustments in favor of an annual two percent prospective operating adjustment meant to compensate hospitals for most unexpected cost increases.<sup>86</sup> This would allow rates to be set only once annually. This annual rate adjustment, coupled with an expedited voluntary settlement process to clear out the backlog of past years' appeals, would put New Jersey's system back on a prospective basis where rates are set in advance. These reforms are largely in place for 1991, but real questions remain about how hospitals will respond to a system that forces them to turn inward and examine their own management instead of turning to the regulators for relief. This is not the first time a backlogged New Jersey rate setting system has been cleaned up. If history is any guide, retrospectivity will creep back into the system. Already the Hospital Rate Setting Commission has made exceptions allowing special mid-year rate adjustments for hospitals it deems to be in financial distress.<sup>87</sup> It is also unclear how state regulators will behave the first time a needed hospital in fiscal distress requires a retrospective rate adjustment.

Unfortunately, other key questions about the future of controlling hospital costs were also left unanswered by the Commission. New Jersey will continue to set DRG rates on the basis of hospitals' average historical costs. Even with the new practice of measuring financial performance against benchmarks, there still will be no economic understanding of the true costs of efficiently provided hospital services. Nor is it clear how the hospital rate setting system in New Jersey is to respond to conflicting pressures. Should one goal of the sys-

---

86. *Id.* at 24.

87. New Jersey Hospital Rate Setting Commission, meeting of January 18, 1991.

tem be to stabilize urban institutions on the front lines of society's wars on drugs, AIDS and crime? Should unlimited reimbursement be available for new technologies that increase costs, and should the system assume the aggressive adoption of cost-saving technology? Should the reimbursement system respond to the changing face of health care by, for example, reforming payment for outpatient service to reflect the many settings in which these services can or should be performed?

If the Commission's ambitious agenda for controlling health care costs in the 1990s succeeds, the benefits for payers are clear. However, it is less certain how hospitals will be affected. As the hospital rate setting system entered the 1990s, it also became clear that the challenges facing New Jersey hospitals were different from those of five years earlier. With various rate setting refinements and a prospective operating adjustment in place, hospitals rarely faced financial crises because of an underlying shortfall in revenue. As noted earlier, the DRG system did lead to improved solvency through its guarantee of uncompensated care.<sup>88</sup> Regulators were typically called upon to solve the problems of hospitals facing cash flow crises, even where the revenue picture for the year was solid. Hospitals argued that this was proper because working capital sources had dried up as a result of tighter standards in the banking industry and their own highly leveraged positions. In the past, state regulators had responded to these cash crises with such temporary rate adjustments that involved relatively little scrutiny of underlying hospital management practices, on the theory that it was more important to regulate revenue and that temporary adjustments were "just cash flow." It is now apparent, however, that this behavior let hospitals with serious management deficiencies postpone real solutions. It remains to be seen whether regulators will continue to respond to cash crises in the same manner as they have in the past or whether the price of temporary cash relief will be closer scrutiny of hospital financial and management practices. So far, the limits of a rate setting process applied to politically powerful institutions with well defined constituencies have been all too apparent. Rate setting has generally changed to suit hospital behavior, not vice versa. If state regulators have the will to do so, they can assure that hospitals seeking financial stability understand there is a price to pay: structural change (integra-

---

88. See *supra* notes 36-39 and accompanying text.

tion with community-based services, for example), scrutiny of foundations and related businesses, and review of management practices. No Commission recommendation can substitute for the political will and leadership necessary to carry out this vision.

### VIII. EROSION OF THE ALL-PAYER SYSTEM

Cost control was one focus of the Commission's efforts, but it is clear that the future of New Jersey's rate setting system also rests on the stability of the payer market. Earlier, we outlined the ambitious plans of the Governor's Commission to restructure Blue Cross and create a public purpose entity that would offer insurance to the currently uninsured.<sup>89</sup> This recommendation is meant to stabilize Blue Cross and improve access to health insurance, but it leaves other important issues unresolved.

Perhaps the biggest threat to health care cost regulation in New Jersey is that, since 1988, Medicare has compensated hospitals by using Medicare's own (generally lower) DRG rates for Medicare patients and has not shared in the cost of uncompensated care.<sup>90</sup> While New Jersey is not the only state where regulators oversee only a portion (roughly 60 percent) of hospital revenue, it is unique in asking non-Medicare payers to make up 100 percent of any shortfalls between hospital revenue as paid by Medicare and what the state's DRG system finds reasonable. This shortfall had grown to an estimated 369 million dollars for 1991, reflecting the growing gap between Medicare rates, which have been held down by federal budget pressures, and New Jersey's system with its new prospective rate adjustments. In addition, other payers are paying an estimated 360 million dollars in uncompensated care not paid for by Medicare.<sup>91</sup> Blue Cross and other payers are increasingly vocal in questioning whether the DRG system's guarantee of full reimbursement for Medicare patients has given hospitals an adequate incentive to maximize Medicare revenue. There are anecdotal accounts of hospitals failing to bill Medicare promptly or fully because of the certainty that other payers will make up the difference, but it is unclear to regulators how to enforce the current requirement that hospitals maximize

---

89. See *supra* note 77 and accompanying text; see CARE, *supra* note 57, at 33-34.

90. See CARE, *supra* note 57, at 4-5.

91. New Jersey Department of Health estimate, 1990.

Medicare revenue before charging the shortfall to other payers. Beyond this, real questions exist regarding the appropriateness of asking other payers to pick up 100 percent of the Medicare shortfall. The question before the Governor's Commission was whether New Jersey hospitals would adopt some of the more dramatic cost saving strategies used in other states were they not insulated from the effect of Medicare cuts and whether this would be desirable.

The Governor's Commission addressed the Medicare shortfall problem by recommending that hospitals be reimbursed for only a percentage of the shortfall.<sup>92</sup> A partial reimbursement will certainly redistribute some of the risk to hospitals and possibly patients, rather than asking payers to carry the load alone. This recommendation, however, does not radically change hospital incentives to maximize Medicare revenue but simply changes the marginal price faced by a hospital in deciding how much effort to put into Medicare maximization. The fact remains that what is a relatively invisible cost shift in other states is made very visible, and very political, by New Jersey's rate setting system.

Medicaid's participation in New Jersey's rate setting system has been called into question as well. Medicaid was one of the first payers brought under the state's rate setting authority;<sup>93</sup> now, it could be one of the first to leave. As in most states, the Medicaid program is one of the largest and most visible budget items. Decisionmakers must balance the advantages to Medicaid of participating in a rate setting system against the possibility that the program could strike a better deal, at least in the short run, by independently negotiating with the hospitals. Medicaid is also affected by federal requirements which can, in some circumstances, limit Medicaid payments to what Medicare would pay. In the end, it is quite possible that the problems of maintaining the cooperation of Medicare and Medicaid in New Jersey's system will end up in the laps of the state's representatives in Washington, D.C.

The New Jersey all-payer system has either begun to unravel or has unravelled completely, depending on one's point of view. Whatever interpretation one adopts, the collapse of the all-payer coalition has clear implications for the uncompensated care solution which had been predicated on the concept

---

92. See CARE, *supra* note 57, at 25-26.

93. See *supra* notes 13-14 and accompanying text.

(some say principle) of payer equity. There are those who argue that an all-payer system is unnecessary. In other states, after all, hospitals have made fundamental management changes in response to Medicare's prospective payment system with no regulation at all of costs for non-Medicare patients.<sup>94</sup> It could certainly be argued that aspects of rate regulation in New Jersey insulated hospitals from the need to make these changes, rather than promoting reform. On the other hand, there are those who argue with good theoretical support that a multiple-payer market will never be an effective negotiator against the relatively unified interests of the hospital industry.<sup>95</sup> In this view, hospitals will always shift costs to the least vocal or otherwise effective payer unless a single entity represents the interests of all payers. As noted earlier, an all-payer system may be a prerequisite to the equitable sharing of large uncompensated care and Medicare shortfalls. If this is true, it may mean yet another round of restructuring in the future to preserve the all-payer system.

## IX. CONCLUSIONS

The Governor's Commission on Health Care Costs and all parties with an interest in health care in New Jersey continue to grapple with many of the same fundamental issues: access to health insurance, the effectiveness of different strategies for health care cost control, the appropriate role and shape of government regulation, and the balance of interests among various payers. These are the same problems that are being addressed nationally. But New Jersey's responses, through a Trust Fund, DRG payment, and now perhaps a payroll tax and "pay-or-play" mechanism for financing the care of the uninsured, has been emulated by few other states. A unique set of conditions, including a long history of regulation, activist governors, and a specific federal interest in a cost-control experiment, allowed this system to survive. The environment has now changed, however. The all-payer system, based on Medicare participation, is gone. The cost of caring for the uninsured has become visible through its growth and the mechanism put in place for

---

94. See, e.g., Sloan, Morrissey, & Valvona, *Effects of the Medicare Prospective Payment System on Hospital Cost Containment: An Early Appraisal*, 66 THE MILBANK QUARTERLY 220 (1988).

95. See, e.g., Himmelstein, & Woolhandler, *A National Health Program for the United States: A Physicians' Proposal*, 320 NEW ENG. J. MED. 102 (1989).

its payment. The loss of federal participation in the experiment, coupled with the burgeoning cost of caring for the uninsured, has created real strains on the system as it enters the 21st century. Indeed, these strains may well lead to the system's demise.