
Committee Meeting

of

SENATE HEALTH COMMITTEE

“The financial condition of hospitals in the State”

LOCATION: Kennedy Memorial Hospitals-UMC,
Washington Township
Turnersville, New Jersey

DATE: March 30, 2000
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Senator Jack Sinagra, Chairman
Senator John J. Matheussen, Vice-Chairman
Senator John H. Adler
Senator Joseph F. Vitale



ALSO PRESENT:

Eleanor H. Seel
*Office of Legislative Services
Committee Aide*

Caroline Joyce
Laurine Purola
*Senate Majority
Committee Aides*

Freida Phillips
*Senate Democratic
Committee Aide*

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SENATOR JACK SINAGRA (Chairman): I want to thank everyone for attending this morning's health-care hearing. As you know, the Senate President announced a series of hearings in anticipation of a package of legislation that will be introduced this May and June.

With that, our host Senator today, Senator Matheussen, would like to say a few words.

SENATOR MATHEUSSEN: Thank you, Senator Sinagra, and I appreciate the fact that you have been willing to convene the Health Committee down here in South Jersey. Welcome to paradise, as we sometimes say. (laughter) Seriously, though, the Senate President, obviously, had set out a criteria for this Committee to take a look at, I guess, what some would define in very simple terms, the health-care crisis. And you've already conducted one hearing regarding some of those aspects, which are really the health insurance carriers. We're now looking today at the financial conditions of our area hospitals throughout the entire State of New Jersey.

Later on, we'll do other hearings, as I know, for provider issues and certainly, last but not least, but those issues concerning the quality of care, patients. And those are, obviously, all very important cogs in a wheel. If we're going to solve the health-care crisis, or at least improve upon where we are right now, we need to hear from all those elements.

Let me just quickly say thank you to our host hospital today. I see John Lucas, Chairman of the Board at Kennedy Hospital, is here -- having arranged all that has been done here today to have us here in Kennedy so this could come off, as well as Dick Murray, the CEO and President of Kennedy Hospital. I want to thank them both for hosting us here today -- it was very

kind of them and happy that you did -- as well as Joe Devine, who really put the whole show together but couldn't be here today. So we thank Joe in his absence.

With that, Mr. Chairman, thank you.

SENATOR SINAGRA: Thank you.

I think we should have a few words from Dick Murray, our host today.

RICHARD E. MURRAY: Great. Thank you very much.

As the host, I would like to welcome the Committee, welcome my colleagues. It's good to see you down here in South Jersey. I will not take a lot of time, but I do have-- While I have the microphone, I will make a few comments, and I will provide, after the fact, some written testimony for the Committee.

I think the topic for today is very good. I liked it a lot -- hospitals' organic financial problems. I liked the term, and I think it's well-suited for today. We're going to talk, I think, about general issues related to the financial status of health-care organizations and institutions in this state. I think, as some of your literature had mentioned, we do not want to spend a lot of time on the HMO dilemmas and the other specifics, but I think you'll hear some very good testimony today on the general financial state of our hospitals.

And to that, I would say a couple of things. I think the crisis is real. I think our industry has cried wolf many times over the 20-some years that I've been here with Kennedy, but now it's really at our doorstep. I think the data is very firm and reliable. Our hospitals are losing money today, and that's not a good thing. We're nonprofit for the most part -- your hospitals in

this state -- and so we do not have any requirement that would say we need to make 10 percent or 15 percent for our stockholders or for others. But most accountants will tell you that we do need to make somewhere in the neighborhood of 2 percent to 4 percent just to stay even to finance our working capital, to pay not for new equipment, but just for the change in technology in equipment when pieces of equipment need to be replaced.

At the Kennedy organization now, we've lost money for the last three years. The first time in the 20 years that I have been here -- lost money from operations, and it's been very difficult for us. And for the most part, it's been the revenue side. The revenue side has been tightened down. All the payers have tightened down what they're paying us, and despite the fact that we've reduced our expenses to the tune of 6 million, 11 million, and 8 million in three consecutive years, we're still struggling and need to reduce further.

And why that hurts the community is that we have to, when we're finished with our reorganizations and our redesigning and our restructuring, we have to look towards reducing the services that we provide. And we have closed down a number of family health centers and clinics, and we've deferred other plans that we had. For example, not long ago there was a major push on the health status of the community, and we had a fairly significant program in the wings that we've canceled because of the cost of that program and the lack of obvious return on such a program.

So I think the deficits are real, and it's starting now to hurt health care in this particular state. In addition to that, if we had the majority of our hospitals were for-profit, I could understand the need to monitor and watch those results, but in a nonprofit organization, as I indicated, there is no

moneys going out to stockholders or others, and these dollars go to the community for programs in that particular community. So I would hope that our legislators would feel good and comfortable about having strong health-care organizations in this state and not weak ones.

I have a couple of other comments, and then I'll give up the microphone to my colleagues. You did have a question in your documentation in here about regulation versus deregulation, and let me just make a couple comments. As far as I'm concerned, either methodology can work and can work successfully. I think it's a philosophic call. If you think health care in general is more akin to police protection, defense, fire safety, I think you would then move in the direction of a regulated environment, and we actually had gotten, many years ago, to a fairly sophisticated state of regulation. And that methodology can work. Of late, we've moved more towards the deregulated state for our health care, and that can work.

Now, it's not been that many years, and it has a lot more to be done in the area of deregulation. And health care, in general, does not lend itself to a deregulated state in the pure sense, in an economic sense. So it's hard to let the free market take place in health care. But nevertheless, my overall comment is either way can work. As providers, we need to know the rules and be given the time to make those rules work.

One last comment, and that is I think that I've seen with this Committee, certainly with John Matheussen down here in South Jersey and others, a real desire to make these things work in health care. I'd like to commend John and the members of this Committee and some of the newer members in the Department of Health in looking at ways to try and get

through the bureaucracy to solve problems. We still have the best health care anywhere in the world. And despite the fact that we have issues that we have to deal with on a day-to-day basis -- the people upstairs here and in the halls of the facilities of my colleagues here in this room -- we're providing excellent health care to people out there, and we're working like hell to do that. So we'll continue to do that, and we appreciate your help in working with us to make the system better.

Thank you.

SENATOR SINAGRA: Thank you.

Any questions? (no response)

Thank you.

Before I call the next speaker, just a few ground rules. I promised the members that we will try to end this hearing approximately at the 12:00 range, which means that I really want to limit everyone's testimony to, also, a 10-minute range. As Chairman, for those of you who have testified before my Committee, I'm very reluctant to cut anybody off when they're up here. However, out of courtesy to everyone else that's here, I'd like you to try to maintain that 10-minute time frame. We're keeping track of who doesn't. (laughter) And I just want to say when we do the Charity Care formula, (laughter) that certainly will be taken into consideration.

With that, or I'm sure is going to give us a very optimistic view, Gary Carter, representing the New Jersey Hospital Association.

G A R Y C A R T E R: Good morning. I appreciate being given the opportunity to be here, and I'll keep my remarks to less than 10 minutes for sure. Let me just begin. There's a cartoon in a recent *Bergen Record* where the

patient is standing talking to a nurse, and the patient says, “My doctor says chances of survival are excellent,” and the nurse says, “For you or us?” And I think that’s one of the things that brings us here today is that we’re really concerned about the overall state of health care in New Jersey.

At the close of 1999, New Jersey’s hospitals found themselves experiencing their worst financial hardships in over two decades. This comes directly on the heels of 1998, which was an equally bad year. I don’t think I am exaggerating when I say that most hospitals in this state will not be able to sustain another year like this.

Today, I want to talk to you about three factors which contribute to our current status: One, the impact of the Federal BBA, which cut \$1.8 billion over five years; two, the growing number of uninsured, which usually end up being treated by our hospitals and are often charity care or bad debt cases; three, the impact of managed care.

Before I discuss these three factors, let me give you some background. We began to see hospital’s margins slip in 1996, just three short years after our industry became deregulated. Unlike some of our neighboring states, New Jersey’s hospitals were not able to build up significant reserves under the old rate-setting system. Under regulation, hospitals were made whole for their full financial requirements by the State. Hospitals were protected against severe losses, but they were also restricted as to the level of profits they could make. This limited the reserves hospitals could build in good years, essentially a rainy day fund. Now, years later, with reduced payments for services, the norm for all payers -- Medicare, Medicaid, and

managed care -- the lack of reserves has placed many of our hospitals in harm's way.

It is important to remember that New Jersey's acute care hospitals are not-for-profit entities. Any profits generated by our facilities are poured back into serving our communities. Our profits do not go into the pockets of shareholders, as would be the case if we were for-profit, investor-owned entities.

I'd like to share with you the latest financial facts on our hospitals, and then elaborate on what I feel are the primary causes of this crisis. First, the hard facts: Through the end of 1999, hospitals in New Jersey lost 160 million from operations. This equates to an operating margin of negative 1.6 percent. This loss follows a loss of 172 million from operations in 1998, for a total two-year loss of 332 million. More frightening is the fact that 65 percent of our hospitals are currently operating in the red. Two-thirds of our hospitals are currently losing money.

I recently had the opportunity to speak with one hospital trustee board, and I presented to them with the bad news-good news scenario. The bad news was that their operating margin was just 1 percent. The good news was that they had one of the 10 best hospital margins in the state. We have truly fallen from far when a 1 percent margin gets you into the top 10.

When we take our State's average for financial indicators, such as margin, days cash on hand, average payment period, and days in accounts receivable, and compare those averages in published Standard and Poor's criteria for a bond rating below investment grade, our hospitals do not fare

well. It almost seems that not a week goes by without another hospital's bond rating being downgraded.

The reasons for this precarious fall are numerous. Some forces are external, while others are internal. First, the external forces: The five-year-long Federal Balanced Budget Act, which became effective in 1998, reduced Medicare payments to hospitals by 1.8 billion from 1998 through the year 2002. In 2002 alone, the cuts will amount to almost one-half of 1 billion. Provisions contained within the BBA that live on past 2002 will cost hospitals in New Jersey an additional 250 million each year and every year.

Although Congress worked hard last year for the BBA Refinement Act, the impact on New Jersey will be a softening of the BBA by about 100 million from 2000 to 2004. One hundred million divided by 81 acute care hospitals over five years amounts to a couple of hundred thousand in relief per hospital per year. It was a good beginning by Congress, but it does not alleviate the huge impacts of the BBA.

At the state level, hospitals continue to struggle with the rapidly increasing uninsured population. At last count, the number of uninsured in New Jersey was over 1.3 million or almost 17 percent of our population. Many of the uninsured find their way into the State's Charity Care program. Based on the State's methodology, hospitals provide approximately 520 million annually in charity care. The State's Charity Care Subsidy reimburses hospitals 320 million for those services -- a 200 million shortfall.

The Charity Care Subsidy distribution formula, as currently written, leaves 35 hospitals who provide substantial amounts of charity care

with no subsidy at all. Another handful of hospitals get just pennies on the dollar for the charity care they provide.

The Governor's Fiscal 2000 budget proposal contains a recommendation to expand Charity Care Subsidy by 30 million via supplemental flow that follows to some degree to the 35 hospitals that currently receive nothing. We think this is a great start, but feel strongly that instituting a hard floor that would provide at least 50 cents on the dollar to every hospital that provides charity care is the most appropriate action the State could take to fix the Charity Care gap, and that would cost \$60 million.

In addition to the BBA and Charity Care, the hospitals continue to struggle with payments from managed care organizations. It has been estimated the HMO's denial of payment for services rendered to patients by hospitals in New Jersey amounts to 200 million annually, almost equal to the amount of reductions, payments to hospitals where HMOs pay for alternative levels of care even though the patient was treated in an acute care setting. Together, these factors, Medicare cuts, the Charity Care gap, and the HMO payment practices, will reduce payments to hospitals by almost 800 million in 2000 alone.

The recently released report by the Governor's Advisory Commission on Hospitals identified several issues that are internal to hospitals and is a part of the poor financial performance. High Medicare length of stay and excess capacity were established as two areas where improved performance would allow hospitals to control their own financial destiny. We are aware that these are two areas where hospitals can help themselves, but I'd also like to add we are working feverishly in both areas.

In 1993, the Medicare length of stay in New Jersey had decreased by 35 percent, while the national Medicare length of stay had come down by only 21 percent. The Medicare length of stay in New Jersey is falling at a rate almost twice as fast as the national average. The Governor's Advisory Commission report stated that reducing Medicare length of stay by 1.6 days would save hospitals 600 million.

It is important to remember that the days that are cut out of a patient's stay are from the back end of the stay, not the front end, and therefore, are much less costly. Our own analysis shows that 1.6 days off the back end of the Medicare length of stay would reduce costs by approximately 100 million to 150 million, not 600 million. Nonetheless, our aggressive reduction in Medicare length of stay over the last several years shows that hospitals are willing to do what is needed to make these changes.

As for the capacity issues, since 1996, four hospitals have closed their acute care doors -- Zurbrugg-Riverside, United, Montclair, and South Amboy -- representing 840 beds. Plans for taking an additional six sites out of the acute care business are currently in process. These additional reductions will eliminate 1531 beds for a grand total of almost 2400 licensed beds and 10 acute care hospitals in less than four years.

In an attempt to reduce payroll expenses, hospitals and hospital systems have systematically removed personnel from their employee rolls through early retirements and eliminating vacant positions.

NJHA is also working with its members to explore alternative uses for vacant beds. Converting to nonacute care services, or long-term care services, will provide for better use of unused beds and also assist in reducing

the length of stay for the acute care population. Staffing, capacity, and length of stay are areas where hospitals can help themselves through the crisis, but we cannot do it alone. Assistance at the State and Federal level is incumbent to our survival.

We view ourselves as an industry with a vision that is shared by the State and Federal Legislature. Our vision is to provide comprehensive, quality, affordable health care to our communities. Hospital mission statements have survived the last 100 years, and collectively, we intend to ensure that I will survive the next 100.

Thank you for your time.

SENATOR SINAGRA: Thank you.

Any questions?

SENATOR MATHEUSSEN: Gary, thank you for coming down here today, and I appreciate your testimony. Let me ask you briefly just two things. I don't expect an answer from you today, but I would like if you could -- if the Hospital Association, as a group, could put together any plans or any thoughts that they might have in how New Jersey can improve on the uninsured population in the state -- any ideas that you have. I spoke to a group of underwriters and brokers just this past -- beginning of this week, and they've come up with some ideas. I'd like to hear from the Hospital Association itself on how we might have more people insured in this state, as opposed to fighting the trend that we're in right now.

The second thing is, if you might answer now, you said in order to get your 50 cents on the dollar on Charity Care for the hospitals would require-- What was it?

MR. CARTER: Sixty.

SENATOR MATHEUSSEN: Sixty million on top of the 320 million that we're at right now?

MR. CARTER: Correct. Right.

SENATOR MATHEUSSEN: So you're talking about a total of 380 million in this budget--

MR. CARTER: Correct.

SENATOR MATHEUSSEN: --to come to 50 cents on the dollar?

MR. CARTER: And also, it's really only 30 million from the State and 30 million from the Feds. So it would cost the State an additional \$30 million because of the matching provision.

SENATOR MATHEUSSEN: Okay.

MR. CARTER: Let me just, to respond to the first one.

SENATOR MATHEUSSEN: Sure.

MR. CARTER: There is, within the Governor's budget, a Family Care program.

SENATOR MATHEUSSEN: Yes.

MR. CARTER: And that's a good start. I think that's padding to the-- We have children who are insured. Having their parents insured is a good way to start this. But I'd be happy to get back to you soon with a proposal or some ideas.

SENATOR MATHEUSSEN: And don't be afraid to be analytical, if you would, on that Family Plan that's out there. Tell me whether or not you think it's a plan that's worthwhile pursuing or should there be other plans, okay?

MR. CARTER: Okay. Thank you.

SENATOR MATHEUSSEN: Thanks.

SENATOR SINAGRA: Senator Vitale.

SENATOR VITALE: Yes.

Thank you, Gary. Can we identify which hospitals are in the deepest trouble and which you sort of see will close within the next year or two? I hate to put you on the spot, but--

MR. CARTER: That's okay. You do put me on the spot, I know.
(laughter)

We have a process where we've gone through and identified probably 10 hospitals who can't meet a triple B-minus rating in terms of their bond rating. But I don't know that it will close. Closing a hospital in New Jersey is not very easy to do. But we do have something in place that we've been looking at, and we've been working with those hospitals to talk about their situation. I know this State has, through the Department of Health and Senior Services, been working with them as well.

SENATOR VITALE: How prepared do you think the Department is to deal with future closings or hospitals that are already in trouble that are doing all that they can to stay alive? I guess the point I want to make is that in the District which I represent Memorial closed and, God willing, it will be reinvented as an emergency care facility or some such thing. But for as long as I can remember, Memorial Medical Center was in deep financial trouble. Some of it was their own doings, and some of it was external.

MR. CARTER: Right.

SENATOR VITALE: And it seemed to me that the Department was, whether it was this administration or the administration before this one and maybe the administration before that one, fully aware of the financial difficulties that they were-- And so my point is that no one sort of came to the rescue, no one even made a phone call, no one said, "You're sick. We'd like to help." And while we can't sort of mandate or dictate to you in terms of what you ought to do to try to make yourself whole, what do you think they ought to be doing -- and just a general--

MR. CARTER: Short of just an infusion of cash, I don't know what they can do. I mean, they can say these-- "Can we work with you? Can we help facilitate a closing or a merger?" I think that would be very helpful, but at the present time the process can be political, and it's difficult. I mean, one of the things that we're saying is that there probably should not be a certificate of need for closing, because that just lengthens the process out and makes the hospitals even lose even significantly more money. And if there could be a way that we work together where we know there's a hospital and it makes sense to close--

Now one of the things in the Commission's report, and I think is in the budget, is some money that would help -- if a hospital decided to close, they could help retire their debt. And I think that's a good effort, because one of the things as a board, you say, "Gee, we owe all this money if we close. What happens to the debt?" So you've got to look at that whole system. I do think that things are being done, but remember, we were regulated. We've only deregulated rates. We really haven't deregulated the process. So when

we decided to make it more competitive, we knew hospitals would close, but it's painful.

SENATOR VITALE: Well, just, I guess, the point, too, is that after we get out of the business of regulating hospitals, it doesn't mean that we don't still have the obligation to the communities that they serve to ensure that any transition is done with full disclosure and that the community is aware of the process every step of the way. The community at Memorial, for example, they had 435 employees who one day were working and the next day they weren't. That all came as a shock to them and their families and the children who -- most of whom went without health insurance for quite a period of time.

So the concern that I have is that -- believes that the State has a moral obligation to provide as much information, as much cushion, and as much help as they possibly can to all the hospitals that are in trouble, so that when they see that they're on the brink of disaster, that they are fully capable of stepping in and protecting the people to whom this hospital serve and people that work there.

MR. CARTER: It's a significant catch-22. If we announce there's a hospital in trouble, you tend to lose your best employees because they're concerned. The doctors say, "Well, gee, what's going to happen here," and they move patients, and we make the situation-- I agree with you. We should be doing as much as possible to help in this transition. I think there are some things under way, like, for South Amboy creating this center, or whatever they end up calling it, that could be done in communities where we can say we're closing, but we're still going to have services available to you. I think that's a

good thing that should happen. And once those regs are approved in the fall, then there's alternatives for the community so they don't feel isolated.

But to think that a hospital-- I think the problem here is that we assume that the hospital is closing because they want to. My experience is the boards don't want to close hospitals. They work as hard as possible to keep them open, but there comes a point where you say I can't, and the public should really trust the board that they've made the right decision. But we tend to think they haven't. I don't think they'd want to.

SENATOR SINAGRA: Gary, I know there's probably no simple answer to the question, but do you see any correlation between the hospitals that have the most dire financial problems and their vacancy rate as to how many empty beds they have on an average day?

MR. CARTER: No. Interestingly enough, most hospitals have staffed at the number of patients they have. They have all these extra beds. They may have a fixed overhead, but it's not -- there's so many factors hitting the hospitals. You can have a lot of beds, and they could be full. You could have 100 percent capacity, but if managed care is denying the middle of the stay, the end of the stay, you're losing money. We have a high Medicare margin and a lot of Medicare patients -- I mean, a high volume of Medicare-- Let's say 70 percent or 80 percent of your patients are Medicare, and they're reducing the payment to you. You could be losing money. So there's just not one easy solution to this. I think it's several factors.

I'd be happy to go back and look at occupancy rates and zero in just on those hospitals at the -- and tell you exactly what we see.

SENATOR SINAGRA: Thank you.

MR. CARTER: You bet. Thank you.

SENATOR SINAGRA: Patrick Donofrio.

PATRICK J. DONOFRIO: Good morning.

SENATOR SINAGRA: Good morning.

MR. DONOFRIO: Thank you for allowing me to speak. I'm an alderman in the town of Dover. I'm also representing a coalition that's a good segue to Gary's talk, because I feel that I'm representing those voices that are going to feel displaced by the loss of our acute care beds at the former Dover General Hospital, now referred to as St. Clare's-Dover.

I don't plan to read all this stuff, of course, but--

SENATOR SINAGRA: You can in 10 minutes. (laughter)

MR. DONOFRIO: I just wanted to show you when they say get involved-- I was a labor candidate, and I was fortunate enough to get elected, and I feel the responsibility to represent the working families. This is just the amount of stuff that I've had to plow through that says nothing for the time I've invested in learning about the subject matter that I have to confess I knew very little about before I got close to this issue.

We have a coalition of about 10 municipalities representing-- There's probably under 200,000 folks. We've got the Urban League, the Morris County Organization for Hispanic Affairs, because we have a large poor population in our municipality. The surrounding municipalities have also weighed in and -- feeling the need that they have for this hospital.

Just back in July, to give a little personal anecdote, before this story broke that the hospital was in danger of closing, I remember going one summer night to the ICU unit to visit three folks. I just went from one bed to

the next -- an uncle in a coma, another relative with congestive heart failure, and I have to say, somebody I ran on the same ticket with for mayor who stopped breathing. Maybe that was a good thing for me to see, that that hospital had a lot of connectiveness to the folks that I'm supposed to be doing advocacy for.

I've learned a whole lot about this. We were a very organized coalition. We've hired attorneys, health-care consultants, financial analysts, an architect. We studied the financial condition, as best we could, of the hospital system that wants to do this. As best we could, I say, because they've been very lacking in furnishing us with any information about their financials. We had to go to public records and piece together what we could.

Yesterday, I spent some time with Commissioner Grant, in Trenton, and her staff. After she had to leave the room-- Because our coalition, being this organized, has our iron in the fire, going through the process where the Commissioner had to leave the room, because she's going to have to weigh in on this at some point.

But in talking to our consultants, knowing that I was coming here today, one thing that they recommended that I ask of you -- because at certain points yesterday it kept getting to the point where the Commissioner's group was at an impasse and the law kept becoming the obstacle. And you're the folks that deal with the law -- this deregulation of the rate setting, the deregulation of certificate of needs -- this is where your forte is. We ask that some sort of a community feasibility study for the distressed hospitals be something that might have some funds appropriated so that-- And we think there might only be about 15 studies that might be needed and to be talked

about, according to my consultant. It will help the transition group at the Department of Health and Human Services (*sic*). It will make the case for what we feel is the case that needs to be made, that the demographics support the need for an acute care medical-surgical facility for this western part of Morris County.

None of the municipalities have broken ranks on this. They all get it. I recognize, in reading through everything, that hospitals are distressed. I hope you find a way to navigate through these waters. I see there's some hope on the horizon. There was \$100 million recently for a bailout of the HMOs. Hopefully, our hospital system will reap some recuperance from that. Also, I see that the census has some information about mega -- What's the word now? -- megagroupings, where Philadelphia and New York type of regional arrangements could help with -- our headline was \$3 billion that could benefit hospitals. So I've been working on our Congressional delegate to see if that's something that our delegation would want to sign on. Anything that can help this process--

We're trying to get out there and roll up our sleeves and do the good work. I just trust that you can see your way to helping the folks that need to have you weigh in on their behalf.

SENATOR SINAGRA: Thank you.

Any questions?

SENATOR MATHEUSSEN: Just as an aside, we didn't bail out the HMOs. We voted to, hopefully, bail out some of the providers who--

MR. DONOFRIO: Right.

SENATOR SINAGRA: Maybe your hospital.

SENATOR MATHEUSSEN: Yes, right, including your hospital.

MR. DONOFRIO: Thank you.

SENATOR MATHEUSSEN: Thank you very much.

SENATOR SINAGRA: Thank you.

Barry Ostrowsky. Barry here? I know Barry, from Saint Barnabas.

(no response)

Tom Terrill, now that he's coming in with a glass of water, I assume. (laughter)

THOMAS E. TERRILL, Ph.D.: Yes. Thank you.

Some elements of my presentation today will be technical, and I have brought representatives from O'Conco Health Care. They are financial consultants, and if we have in-depth technical questions, Paul Chiafallo or Trish Aberle will help us address those, but thank you for having the hearing.

Senator Matheussen, thank you for hosting it.

Senator Sinagra, thank you for sharing it.

I'm Tom Terrill, President of the University Health System in New Jersey. Our organization represents 12 of the state's major teaching hospitals, and the University of Medicine and Dentistry of New Jersey. I've also been asked to testify today regarding the financial status of New Jersey's hospitals and to identify possible legislative solutions.

As Mr. Carter pointed out, New Jersey's hospitals are in a state of fiscal crisis. There are 82 acute care hospitals in New Jersey, 66 percent of which have negative operating margins. There is a chart in the presentation, Chart A, which will demonstrate that. An interesting dichotomy today finds that New Jersey hospitals' finances and HMOs' finances are moving in

opposite directions. A recent report by Standard and Poor's estimates that, while New Jersey HMOs maintain strong financial ratings, New Jersey hospital credit ratings continue to drop.

New Jersey's financial crisis hit a fever pitch at the end of 1998. The warning signs began to appear as early as 1996, as hospital CEOs began to identify the source of their problems. The more notable of them was the annual Charity Care shortfall of over 200 million and projected for year 2000 at close to 300 million, increasing levels of managed care denials, and the five-year impact of the Balanced Budget Act. The issue of hospital financial stability was clearly on the table, and at that time, under the direction of Governor Whitman, the Department of Health and Senior Services reconvened an existing Health-Care Commission to identify the true extent of the financial problems and to make recommendations for solutions.

A complete review of that report was presented by Sean Hopkins, Vice President of Health Economics for the New Jersey Hospital Association, in the February issue of *The Garden State Focus*, which you have been provided. A second article in that issue is by me on the Medicaid payment shortfall.

The work of the Commission relied heavily on four reports: A study performed by PricewaterhouseCoopers, commissioned by the State's Bonding Authority, who you will hear from later today; the New Jersey Hospital Association's financial status of New Jersey hospitals; and information provided by the New Jersey Hospital Alliance and the University Health System of New Jersey. Each of us described essentially the same bleak picture -- all hospitals in New Jersey have been on a downward financial spiral since

1996. The number of hospitals operating in the red was increasing each and every year.

Each report also cited the same three external forces as problems: Charity Care and Medicaid payments, because those are what drive Charity Care payments is the Medicare rate; HMO denials; and the Balanced Budget Act. The PricewaterhouseCoopers study also mentioned slower-than-needed reductions in length of stay. New Jersey's hospitals have reduced their length of stay by over 27 percent since deregulation in 1993. You have to move slowly and wisely, and there's a lot of education with your medical staff involved in this. Persistent and excessive hospital capacity, no argument-- Higher staffing levels, in our view, we think that's good. I'm not sure that I want to have my hospital staff like Boise, Idaho or Bear's Breath, Montana. (laughter)

SENATOR MATHEUSSEN: Sounds like you have personal experience on those two.

DR. TERRILL: Yes, I do, as a matter of fact. You know, go to Sun Valley, we have a 50-bed hospital and one nurse in the evening. She usually pushes around a cocktail tray. (laughter)

And we also have-- They pointed out board ambivalence about transitioning services or closing hospitals. Is it possible that they could be worried about regulatory or legislative interference? Why don't you talk to the people at Point Pleasant and see how hard it has been for them to close that place. And you just heard from Dover.

Recommendations from the Governor's Advisory Commission cover many areas, and I am sure you will hear more from the New Jersey

Health Care Facilities Financing Authority about its recommendations today. However, three of their recommendations in the Advisory Commission, I think, are critical: Increased Charity Care funding, rebase the Medicaid rates, and update the DRG grouper. Interestingly enough, the Department of Human Services will tell you that they have no intention of rebasing the rates this year or changing the DRG grouper. It's based on a 1998 economic model. I think that's 12 years old.

SENATOR SINAGRA: 1988.

DR. TERRILL: Eighty-eight. What did I say, '98?

SENATOR SINAGRA: 1998.

DR. TERRILL: It's '88.

The direction on the balance of my remarks today will focus on, I think, the State's responsibility in providing adequate payments for State-mandated programs. Why? Because three hospitals are in a death spiral and will close before year's end. Further, New Jersey will see an explosive growth in hospital closures unless immediate steps are taken to remedy the situation.

The State of New Jersey has mandated that hospitals provide care to anyone who presents themselves at their facility. However, the State has only halfheartedly shouldered its financial responsibility under the law to pay for the care provided. Considering the constitutional amendment adopted in January of 1996 which talks about government and education and service industries, which deals with unfunded mandates upon boards of education, counties, and municipalities, I would like to point out that we are operating

under a double standard by which the State treats one of its most important service industries -- New Jersey's hospitals.

This failure by the State to live up to its responsibility is demonstrated in two ways. Charity Care costs at the Medicaid rates, which haven't been increased in over seven years -- in fact, they've been cut by 200 million in the last six years -- point out that Charity Care value at those rates, those outdated rates, was 520 million. And the State paid 320 million. Charity Care reimbursements are grossly underfunded, and they're unfair due to the use of an antiquated and archaic distribution formula. I have presented you with a graph of two hospitals that are less than 12 minutes apart by driving time; one provides \$36 million worth of Charity Care and gets 37.5 million in reimbursement; and the other one provides over 15 million in Charity Care and gets zip, nothing.

Cuts in payments for Medicaid services rendered-- Reimbursements are now 24 percent below costs or 200 million. There's a chart in there that will explain that one. (indicating statement) When we started in 1992, the State Rate Setting Commission allowed a 10 percent kicker to Medicaid rates so that hospitals could make it through the transition without severe cash flow problems. The State then, two years later, took that 10 percent away, and that was the first cut. And then there's a series of cuts that took place since that time, plus the Department's intractable stance on the fact that they do not want to change to a updated grouper or change the Medicaid rates at all.

Another example of the double standard employed by the State with regard to its own hospitals is the disparity in payments made to New York

and Pennsylvania hospitals with regard to Medicaid rates. The State actually pays higher Medicaid rates to out-of-state hospitals for New Jersey Medicaid recipients than to their own institutions within the state. If this continues, we can simply ask all of our Medicaid and Charity Care patients to go across the rivers for care, for there will be no hospitals left to provide services to New Jersey citizens.

I want to be perfectly clear. This \$500 million shortfall in State payments for legislatively mandated care is the principal reason that the fiscal crisis in New Jersey hospitals exists. The BBA will affect us over the next three years, yes. No problem about it. Yes. Payments denials by the HMO industry is hurting the industry. But when you take a \$10 billion industry and you whack 500 million out of it every year, you are going to create fiscal crisis. By the way, the payments of these funds to hospitals would not contribute to their operating positive margins. These are payments based at costs for providing this mandated care.

Okay, now that I've told you what the problem is and defined it our way, what can the State do to remedy the situation and meet its financial responsibilities under the law? First, I think they should pay all the hospitals for their Charity Care services, not eliminate 35 of them and say, "Oh, by the way, you live in a nice neighborhood. You're not going to get any money." An additional 300 million, of which, by the way, the Feds would pick up half that cost-- Now, we can't help it if the Medicaid payments that come from the Federal government are absconded and put in the general revenues, but that's what happens. But that's how the State justifies to the Feds getting their payments. They say, "Oh, we're going to pay X number of dollars." They get

it matched, and then we never see it. So an additional 300 million, which would be Federally matched, so the net cost to the State is 150.

Restore the \$200 million in Medicaid cuts, which would also be Federally matched. So what's the real effect? One hundred million. Abandon the unfair Charity Care formula and pay hospitals on a documented case-by-case basis. The total cost for this would be a \$250 million price tag. The State just got a \$900 million infusion from the Federal government, which will go forward at 300 million. It just got a series of tax payments for the tobacco industry. And, in this time of incredible budgetary surpluses, I don't think the State should be holding back and supporting one of its most valued and treasured investments.

We were encouraged to learn that the Governor was trying to be responsive to the crisis, but we were deeply disappointed to hear that her budget adds only 30 million to the Charity Care coffers and makes no mention of changes in the Medicaid payment rates. So you still will have hospitals, like Cooper, like University, like Morristown, like Robert Wood, like Jersey Shore, who will be providing the care. They might get 25 cents on the dollar, but at an old, outdated, decades-old payment rate.

Again, let me say, at a time of full employment and dramatic budget surpluses, surely the provision of health care to New Jersey citizens merits better attention and fiscal support.

Again, I would like to thank the Committee and Committee Chairman Sinagra for the opportunity to provide you with our views on the important facts considering this issue. I am prepared and we are prepared to answer any questions you may have.

SENATOR SINAGRA: Do you have any questions?

SENATOR MATHEUSSEN: No.

SENATOR SINAGRA: Senator Vitale?

SENATOR VITALE: The Charity Care issue, in terms of the impact it has on hospitals, are you able to tell me if the State were to reimburse at near 200 percent for the Charity Care load the hospitals -- the two hospitals -- particularly those that are distressed, do you have any sense of how that would affect their financial health?

DR. TERRILL: Absolutely. For one hospital, let's say, (a) Morristown, that's 7 percent of their business, and it's growing. It's doubling every year. Why? Because the number of uninsured is doubling every year. So if you add 7 percent back to their bottom line, all of a sudden they break even. This is the first time, two years in a row, they've lost money. If you were to do that for the Cooper System -- I'll let Les Hirsch speak to that. But if you were to do it for University Hospital, keeping in mind you've got to also change the Medicaid rates because they're 24 percent below cost, if you were to make that improvement first and then add the moneys into Charity Care rather than into the Medicaid Program, put the money in Charity Care, improve the rates, then you have a win-win situation. But if you just put more money in Charity Care and don't change the rates, you're still hurting the inner-city, urban institutions that are providing that care at 24 percent less than it's actually costing them. Same thing for the suburban institutions--

So all of us -- not just the teaching hospitals, not just the urban institutions -- every single institution in this state is suffering, because they haven't changed the Medicaid rates, one. Two, if they do that, it will show

how dramatically far behind their payments are at 320 million for the real price tag of 616 at costs. This is for the Fiscal Year 2000. So let's round it up, 620. So basically, that's a minimum of a \$300 million shortfall. You can't ask an industry to keep absorbing those losses and keep their doors open. You are going to wreck the bond ratings not only for the hospitals, but for the State.

SENATOR SINAGRA: Any questions? (no response)

Thank you very much.

DR. TERRILL: Thank you.

SENATOR SINAGRA: Alex Hatala.

A L E X A N D E R J. H A T A L A: Good morning. My name is Alex Hatala. I'm President and Chief Executive Officer of Lourdes Health System, which includes Our Lady of Lourdes Medical Center in Camden and Rancocas Hospital in Willingboro. I want to thank the members of the Senate Health Committee for this opportunity to give testimony on the financial conditions of hospitals. I'll also say, as I'm starting, that I'm taking a break from our triannual joint commission survey. So I think as the crisis goes on, the expectations for hospitals don't lessen at all.

The joint commission is the agency that accredits hospitals for the Federal government. I think that the point of the comment is that the consumers' expectations are still there. The Federal expectations are there. Your expectations are there for quality of care, and there is no opportunity to cut corners or to do things in a half manner because, ultimately, it does come down to the patients in our community.

I wanted to give you a little bit of a sense of who we are. Lourdes was founded in 1950. At that time, Camden was a prosperous community, as

all of you know. In the '60s, when there was a great exodus from the city, both commercial exodus and I think population exodus, we made a commitment to stay in the city of Camden. Our mission drove us to do that. We've maintained that mission for the past 50 years or so.

I would tell you that Camden, as you know today, is the fifth poorest city of its size in the country. So it's not only an enigma for the State to deal with, it's also the fifth poorest city of its size in the country. I think that we've committed there, but also prospered there. When you look at our accomplishments, for instance, and you look at the indicators of performance -- I know that's some of your questions this morning -- I think they're exemplary.

For instance, in 1995, we were winners of the Foster McGaw Award for hospitals. It's a national award given to the one hospital that best demonstrates its commitment to the community and improving the community's health. Just to give you a sense of how competitive that award is, the runner-up that year was Johns Hopkins. Our last joint commission survey, again, three years ago, we received a score of 98 accreditation with accommodation. So again, our quality is exemplary.

So let me talk about our financial performance, which is the other indicator of our performance. I think that our record, as an institution, is without question. Ironically, despite a booming economy, unemployment at generational lows and a trillion dollar budget surplus at the Federal level, we're here having this discussion today. There is a major impact on New Jersey hospitals. We're also part of a national health-care system. I get to see the results of 33 other hospitals up and down the East Coast. I can tell you

emphatically that our results in New Jersey are much worse than those in other states.

In 1998, and as Mr. Carter said, 60 percent of the New Jersey hospitals lost money, a staggering \$172 million. It's estimated to have increased in 1999, because 1998 didn't increase -- did not contain the one-time rate downs that were not contained in the operating results for '99. That is the HIP and AAAP failures. Liz Sweeney, an analyst from Standard and Poor's, which has been quoted here many times, in the March 20, *Bergen Record* article, said that, "New Jersey hospitals' financial performance remains among the weakest in the nation." According to a recent New Jersey Hospital Association report, the '98 average operating margin for New Jersey hospitals was a negative 1.7 percent, the lowest it has been in the last 22 years.

The financial ratios for the aggregate of all New Jersey hospitals would be rated, by rating agencies, below the Triple B-minus level, which, in essence, is at junk-bond level at this point. Additionally, 40 percent of the \$4.7 billion -- and that's a staggering number also -- hospital debt that was issued through State or local authorities is uninsured. This means that if a hospital was to falter or fail on its uninsured bonds and individuals and institutions lose their money, probably some of your pension moneys are holding some of that hospital debt.

Historically, New Jersey hospitals have been characterized as being high cost in comparison with other hospitals from most other states because the average length of stay was higher. As you heard earlier, we've been working on that. In between '93 and '99, the New Jersey Medicare length of stay has come down 35 percent. Additionally, the inflation-adjusted cost per mission

in New Jersey hospitals has dropped over 11 percent since 1994. However, our revenues have not kept up with this pace with the revenue growth experienced by hospitals elsewhere in this country.

The New Jersey Hospital Association also described our current problems as a confluence of negative forces: Medicare reimbursement cuts of the DBA of 1997, inadequate Charity Care funding, low Medicaid reimbursement rates, and reductions, delays, and denied payments by HMOs.

In 1998, Lourdes admitted 16,250 patients and recorded an excess of revenues over expenses. In 1999, our admissions increased by 3.5 percent over 1998, yet we recorded losses over \$10 million. By far, that was the worst experience our institution has had in 50 years.

Now, let me comment on that loss of \$10 million and your questions on efficiency. When you look at the aggregate efficiency measures that are collected by the New Jersey Hospital Association, Lourdes is in the bottom five or the best five in terms of length to stay, lowest length of stay, in the state out of the 80 hospitals or so. Our expense per admission, on a case mix adjusted basis, adjusted for the severity of patients we have, is also in the bottom five. Our FT's per occupied bed, which is another measure of efficiency, same thing. On the other side, in terms of the utilization of the facility, we're one of the most highly utilized facilities in the state, with a very high occupancy rate in the middle 70s, compared to the average, which is around 50-some percent.

So here's an institution, I think, that is doing the right thing for the community. Again, the Foster McGaw Award, doing the right thing in terms of its indicators of quality care, which is losing its shirt even though it's

one of most efficient hospitals in the state. So I think, when you look at that, you have to say something is not right with the system. By all measures, we are doing the right thing -- treating more patients, reducing the average length of stay, improving quality and patient satisfaction. But a reimbursement from virtually all payers changed so dramatically in such a short period of time that our financial health deteriorated tremendously. We were forced to make some very difficult decisions, and the most difficult of which has been the elimination of jobs.

Last year, we eliminated 11 percent of the workforce in the hospitals -- 324 jobs at Lady of Lourdes Medical Center and Rancocas Hospital. And that was actually accomplished in conjunction with the reduction of services. At the same time that we eliminated those jobs, we also eliminated geripsychiatric services in the city of Camden. So the ability to cut much further is there, but you're going to get into those programs that are essential for the community service.

I could spend hours complaining about the inequities in managed care reimbursement, but I'll let my colleagues do that later, and in Medicare-funding shortfalls. What I'd like to do is really concentrate on Charity Care. Charity Care provides equal access to top quality hospital care for those New Jersey residents who are uninsured or otherwise could not pay their hospital's bills. It's interesting. On the way over here today, I heard a report from a consumer group that recently did a study on access in five Philadelphia area counties, and what they're finding was very similar to what we see in New Jersey, that the Charity Care-- The people that are unable to pay

-- 70 percent of those individuals are employed. And I think that we have a similar experience here. They're the working poor.

The Charity Care system here frees the State from the expensive costs that would be needed to build, operate, and maintain a system of public hospitals. Instead, the State has agreed to reimburse existing hospitals for the cost of providing Charity Care. Unfortunately, I think the State has not fully lived up to that obligation. In the year 2000, New Jersey hospitals will collectively provide an estimated \$520 million worth of charity care, an amount nearly 8 percent higher than the previous year. However, the State subsidy payments to hospitals will be the same as the year before, just \$320 million, leaving New Jersey hospitals with a \$200 million Charity Care shortfall.

Under the State's new and complex formula for calculating Charity Care, 35 hospitals who provide that care, including Lourdes, receive absolutely no Charity Care reimbursement at all. So here's a system that looks at a hospital in the city of Camden, fifth poorest city of its size in the country that has all the attendant social and economic characteristics, that gets no Charity Care. So I would also say that there has to be something wrong with that formula.

SENATOR SINAGRA: Well, you do know, just -- not that I want to interrupt you. Do you know how that formula was derived? The administration, when the formula was being done, decided who they wanted to give the money to, then invented a formula to accomplish where they wanted the money to go--

MR. HATALA: Right.

SENATOR SINAGRA: --to justify it. But that formula, you might as well count the parking spaces in a lot. (laughter)

MR. HATALA: Well, I guess we don't have many parking spaces in Camden, but-- (laughter) Yes, it does work against some hospitals that any reasonable person standing on any street corner would say, "Should a hospital in Camden get Charity Care?" I think the answer would be yes. So I urge the members of this Committee to reexamine the allocation of Charity Care dollars in the state.

Finally, while we remain absolutely committed to our mission of providing quality care to all who seek our aid-- And again, the patients that come to our institutions, when they come into our emergency room, they don't get the question asked to them, "Is there a way to pay for your care?" They're provided the services. We don't ask them. We provide the services. And in many ways, the consumers are really blind to what is happening here with hospitals because of that reality, because we provide the care irregardless of ability to pay.

But I think, even though we're committed to that mission, there's a reality that we live in an economic world, that eventually those economics catch up to us. We weathered the storm last year with a \$10 million loss. We thought we didn't. What we needed to do, in terms of reduction of cost-- But the days of reducing costs are behind us. I think that you are down to the bone, at this point in time, with a hospital like Lady of Lourdes in the city of Camden. I think our ability to weather more years like last year are very limited. And I think in the end, if institutions like ours close, that really aren't providing the services and aren't providing the commitment at the State's

request, we're doing it because we think it's the right thing to do. But if we're not there, you'll need to be there, and I think you'll need to be there at a much greater allocation that you're now making.

Thank you.

SENATOR SINAGRA: Thank you.

Any questions?

SENATOR ADLER: Mr. Hatala, hi. John Adler.

With respect to Charity Care, it seems like you laid out three different issues, each of which is a significant one. One is the formula and how skewed it is to the great disadvantage of many hospitals in this region and throughout the state. One is the level of funding altogether. The third, which I think we have to explore as a long-term part of this, is the fact there's a growing reliance on Charity Care rather than what we hoped would be a tapering off in a strong economy with more people insured. In fact, we got the contrary, with fewer people insured. I know Tom talked about this a few moments earlier. How would you rank what we should do, and in terms of immediate priorities and in terms of long-term priorities, to address the health-care needs of the State of New Jersey?

MR. HATALA: Well, I would tell you that I think that probably the immediate priority is really on fixing the Charity Care formula and get some immediate cash into the hospitals that are providing inner-city services. And that's probably a 12-month objective. I think longer-term is related to Medicaid access, I think, expanding eligibility and improving the efficiency of determining that eligibility.

Family Care is a good start. But I think that, as we look at our ability to qualify either people for Charity Care or for the Medicaid program today, it's a Rubik's Cube. It's very hard to get there. And I think that there has to be a simpler way to qualify people at the point of service that obviously meet the criteria, but I would say that that's probably the longer-term strategy, is expand the Family Care program but make the eligibility much easier.

SENATOR ADLER: Thanks.

SENATOR SINAGRA: Thank you.

MR. HATALA: Okay. Thank you.

SENATOR SINAGRA: Charlie Wowkanech.

C H A R L E S W O W K A N E C H: Thank you, Mr. Chairman, and members of the Committee. I have submitted testimony which is quite lengthy, and I'll try and cut it short because many of the points on Medicare reimbursement and so on and so forth have been, I think, well articulated. But let me just say here today at the outset that I'm here as both the representative of 1 million health-care consumers in this state, as well as an organization that represents tens of thousands of health-care workers in our State's hospital system.

The PricewaterhouseCoopers report, relied on by the Advisory Commission, correctly identified some of the problems facing New Jersey's hospitals. But, as much as my testimony will outline, it misidentified the reasons for the problems. Therefore, the solutions it recommended are impractical and unrealistic, in our opinion.

In our estimation, health care in New Jersey is beset by three primary deficiencies which have contributed to the dramatic increase in costs

and negatively affected our hospitals' financial conditions. No. 1, which you've heard over and over again, and I'm going to have to hit it pretty big here today, is the rise in New Jersey's uninsured population, particularly in the gainfully employed. This is a lesson that we learned from 1992. I'd like to point out to this Commission, back in 1992, when the hospitals were at this approach of running short on cash and laying off people and going belly-up in some cases, there was a Commission put together.

There was a Governor's Commission put together where all the best and the brightest in the Hospital Association, the labor community, the business community, the Governor's administration, developed several recommendations of, one, we're still struggling with that one here today -- the issue of some sort of a broad-based financing mechanism. Borne out of that was-- I call it -- Senator Codey, who is still around -- the infamous bare-bones insurance policy. There were many people, particularly -- and this isn't a knock on unions or nonunion companies. This is, in fact, a very important factor in this dilemma that the hospitals, as well as the people I represent, are in today, and our communities.

At that point in time, the business community cry was, "Rates were going through the roof. Give us an affordable product." Out of this Commission, that administration put together a health-care insurance reform for small group and individual group. It was the broad consensus that the standard policies be designed and would instill competition amongst the insurers, and that the subscribers would very briefly be able to read the five or six plans and wouldn't be able to be gained by words and phrases that were great marketing techniques of the insurance industry. Well, lo and behold,

and it still stands true today, and I want you to really give this some thought because you just-- The person who testified before me hit on it very well. The uninsured population in New Jersey is doubling every year, 70 percent of which is gainfully employed people.

So I ask you as legislators, and I ask you as some people who are businessmen and businesswomen, what's better, something that's free or something that's affordable? The decision is very clear. Today, the plan that was designed back in 1992, the infamous Senator Codey's bare-bones plan that was going to be for about \$1000 for people to buy. Out of the five plans, it was the least-purchased plan. They're not interested in affordable; they're interested in free. That's the problem here. No question about it, Medicare reimbursement rates have been devastated, but if you're going to rely on financing the health-care delivery system in this state on subsidies and Medicare reimbursements and Charity Care, then what you're really talking about is a universal health-care system that's financed by public money, if that's what you want to go to. I think that's very, very unfair.

I also think that it's really incredible as I listen to the hospitals talk about their financial plight, and yet I receive hundreds of phone calls from around the state, from employers that we have contracts with, as well as union fund administrators, that can no longer bear the cost of these premiums and the cost of health care.

So it's just not the hospitals that are in trouble. I want to make that very clear here today. But it all comes back to the same point. If we're going to rely on strictly financial subsidies, if that's the system we want, then we're going to have more layoffs, more bare bones, and more cocktail

waitresses pushing carts around in the hospitals. This is what's going to happen. I know I don't-- I want to fall short of saying a mandate, but I think, as public policy people and a body, that if we require the residents of this state that work in this hospital that when they get in their cars and they drive from their house to work every day, they've got to have auto insurance, it's not too far fetched to say that they should have health insurance if we really want to make sure that our communities are whole and vital and that the delivery system can be in place.

I also want to point out that the move to managed care has really created havoc not only amongst the hospitals, but against the employers of this state and against the workers of this state. We see higher bills, less service, less regulations, hospitals now that want to go belly-up, two HMOs that went belly-up that now the taxpayers have to pick up or share the cost. I mean, it's just incredible. I really think that we're going to have to look at, and I know to Senator Sinagra's point, and I heard Senator Matheussen ask the question earlier about how can we maybe correct some of these people who are free riding the system or the uninsured question. I think it's the State's leadership in view of good public policy for our citizens and our hospital structure around the state.

And just a couple of things, again I know, with no -- due respect to any of the members here, but I've talked to Senator Sinagra about this at great length. And as a senator, as a businessperson, I know he feels very strongly about this, is when we let public contracts for the State of New Jersey that are given out at the lowest responsible bid which allows companies from out of state to come in here -- and again it's based on their ability to underbid

other contractors -- now nothing seems wrong with that system. But if their employees don't have health care and our contractors have health care, then they're at a 35 percent to 40 percent bid advantage over the people that do. So what kind of message are we sending to these people if we're truly concerned about the quality of health care and the delivery system in the state?

We have seen instances where companies from Texas and the Carolinas come into our state, have all their employees classified as independent contractors, have no workers' compensation, have no health care. They get hurt on public works jobs that are highways or bridges or tunnels and State buildings; they end up in these folks hospitals. They get taken care of for nothing, and then they get sent home. I think that's just unfair.

I think we need to look at when corporations or companies or business concerns come into this state because of its great location, its highway network system, its ports, its airports, its trained and skilled workforce. When they come into this state and they apply for EDA moneys or loans or special things, they should not even be considered for that unless they have health-care policies on their employees. I think this is an area where we can start to tighten up some things, level the playing field for not just unions, but for all bona fide, legitimate businesspeople around the state to do business. I think the time has come to really get hold of this.

Let me just throw out another suggestion on the second issue of insufficient disclosure, accountability by the public hospitals, and insurance companies. I mean, I think it's incredible to be sitting here listening to this, while we've been in the biggest boom, post-war boom for seven years. Corporate profits are going through the roof, okay, CEO executives are-- I

can't even put words on how high they are. And I'm not knocking CEOs. Everyone should get paid, no question about it. But in this great period of economic boom, the people aren't receiving care, the lines are getting longer, the services are getting less, the paperwork is getting longer, the hospitals are going belly-up. Something is definitely wrong here. There's got to be another reason.

I would like to know, myself, and I think that the members of this Commission should know -- just as you run a business, every dollar that gets taken into your business or into State government has to be accounted for. There has to be a trail. And at the end, you have to know what comes in and what goes out. I think that, while I'm sensitive to the hospitals' plight and I know they're under pressure just like all of us here in this room, I still remember the Charity Care days of old, when there were a lot of submissions and a lot of abuses and a lot of creative bookkeeping that took place.

And I think what this Commission could really use is an independent -- and might I suggest Rutgers University, which is the public policy arm of our State-- I think an independent commission has to be set up. And I think that we all are entitled to know, out of every health-care dollar that comes into our hospitals or into our insurance companies, we need to know where it's really going, because it's not going to patient care. The hospitals are saying they're broke. They're laying off people. Some will tell you they're doing it through attrition. Some will just tell you the truth outright, they're getting rid of them, okay, because they have to survive. Make no mistake about it, they got to survive.

So I think we should know, while all this money to Medicare reimbursement, which we know is shortsighted, the Charity Care, which everyone is asking for more, we should know what happens to all this money. Who gets it? Does it go to the executives? Does it go to administration? Does it go to patient care? Does it go to the pharmaceuticals? I mean, I think we really need to know where the money trail is so we or you, as legislators, can make intelligent decisions here as to the future of our health-care system in this state.

My third point in closing is the failure of deregulation in terms of now we're going to see hospital closings out of this commission, with 10 hospital closings. I think it was illustrated here that there are some communities in our state, and this is another sad point, where the largest industries in those communities are either police stations or hospitals. Okay. And if you're going to talk about closing these places, I think you're going to have to look at what the offset of that is in terms of welfare, in terms of unemployment, in terms of people who get into all kinds of problems with personal bankruptcies and how do they pay for their college kids' educations. Do they work four jobs now instead of two jobs? I think that there has to be some thought into maybe worker retraining or to prepare these people so that they can subtly and gently move into some other expanding area.

I know what Senator Vitale did in Amboy -- and find alternate uses for the hospitals. I think that, maybe, has to be looked at. I get back to the basic thing. A lot of money is being spent here. A lot of money is being spent here, even though it's not enough on Medicare, on Charity Care, on our insurance premiums. But we really need to know, ultimately, where does that

dollar go when it goes through our system. I think once we have that answer we'll be able to work on the rest of these.

So I appreciate the opportunity to come before you. I've spent some 10 years in the whole health-care dilemma, as most of you know. Again, the people that we represent, the industries that we represent, we want them to be here. We want them to stay here. We want them to have health care. We want our hospitals to be healthy. I look forward to working with you and each and everyone in this room into making that become a reality. So I thank you very much.

SENATOR SINAGRA: Any questions?

SENATOR MATHEUSSEN: Just a comment, if I could.

Charlie, I want to thank you for your testimony today. I do remember the days. I think all of us here, perhaps with the exception of -- only because he might remember them but he didn't sit on the Committee at that time, and that was Senator Vitale, but remember the days when we took a look at Charity Care in the State from over a billion dollars a year, and some would say -- and I couldn't argue with them -- that we cut it drastically. And draconian cuts, that may not have been absolutely the right thing to do either. But going back to the years of 1991 are not the right things to do either.

Your testimony and that of Gary Carter, the President of the Hospital Association, were somewhat hand in hand. You mentioned a couple of things that he thought were the real critical areas of what we needed to address and that was-- Well, we can't hear the Balanced Budget Act, but certainly uninsured coverage-- That to me is where I've started a long time ago, and I still talk about it. And I do remember Senator Codey, and I do

remember the five policies that we were supposed to have for small group. And the problem is that those five policies do not represent something that's affordable. Everybody wanted those five policies, and they were supposed to be bare bones, some of them, but now they're very rich in the quality or the coverage that they have, and they're also very rich as far as their purchase price.

Unless we can develop something to get people insured-- And I'm not so sure the family package that the Governor's offered is a bad one, but I don't know that it's a great one either because it emulates some of the things that we see wrong already in the small group policies. Unless we can refine those policies, I think we're heading to a situation where -- and I listened to Tom's testimony -- we're heading to a situation where we're looking at government-subsidized health care, period.

MR. WOWKANECH: That's right.

SENATOR MATHEUSSEN: And I don't think I want to be there. I don't want to participate in this system. I want to participate in a system where a government lends the helping hand when they're supposed to. But if we're talking today about completely underwriting all of the health-care costs through government, then we might as well forget the private industry and might also forget all those other things and just go to that system. I don't want to go that direction, and I think we need to work together to help keep Charity Care at a low cost because we have to get more of the people insured.

MR. WOWKANECH: Absolutely. Again, I feel very strongly and was part of New Jersey's KidCare when it was created, but now I look at the next version of-- First, we're going to take care of the kids of gainfully

employed parents who work for employers who don't provide health care. Now we're taking care of them, which is a great thing. And now we're going to take care of their parents. So, as public policy people and officials, what messages are we sending to the business community? Again, my 1992 -- my most distinctive quote was, "Free is better than affordable." If your wife can go to the Wawa store down here every night and get a quart of milk for free and just keep walking in and out and picking it up, why should she pay? I mean, come on. That's what's going on here.

SENATOR MATHEUSSEN: You're absolutely-- And there's a message coming back from the business community. There's a message out there that concerns me. The Xerox of the world. Xerox says that perhaps instead of offering health care to our employees what we might do is give them a stipend every year of \$6500 or \$7000, and they can do with what they want with that money. I would suggest to most of the people here today that they would take that money and probably spend it on other things other than health-care insurance--

MR. WOWKANECH: Right.

SENATOR MATHEUSSEN: --especially if we're offering it for free.

MR. WOWKANECH: That's a good point. I'm probably over the 10 minutes. I'm about to get cut off, but that's something that should be brought out and looked at.

And again, I'm not a person-- Each and every one of you know me. I'm not an anticcompany or employer person. I've spent a lot of my career

working with companies and corporations, building their businesses, and because I think it's good for our workers.

SENATOR MATHEUSSEN: Without business, your membership doesn't happen.

MR. WOWKANECH: But I'm going to be honest, and I wish that the business community would be, too. And I don't blame them, quite frankly. I don't blame them, because they're just like us. They can't afford this. And I think after 30 years of trying to come up with health-care reform, and this is the new vogue thing for the businesspeople, and I love it.

Health care should be the employees' personal choice, and we shouldn't be involved. Let's just give them the money. Know why? Because they realize this is going down. My organization got a 47 percent increase in our health-care premium from our insurer and a 95 percent increase in prescriptions. So, in effect, that's what's happened here. Give them the money now. Let's cut our losses, because this thing is going to keep going. There's no end in sight. We can't fix it. That's what I'm telling you is the message, and let's get out of this. And, at least, we look like we're doing the right thing. We're giving our employees some money and go-- But you're right, people that are trying to live in this state, pay the taxes, want to have what our parents wanted for us, a better future with college and all those things. When the decision comes, do I take that 7500 and pay tuition or do this or do that. We're all going to be in the hospital looking for our free quart of milk.

SENATOR SINAGRA: Any questions?

SENATOR ADLER: Mr. Wowkanech, you talk about the 70 percent of the Charity Care population that has jobs. You came up close to the edge and then you didn't quite step over the line to suggest that maybe the State should have a mandate requiring, in some way, that either the employers of that 70 percent population -- the employers pay for health care by mandate from the government or that-- And I've heard suggestions from some in the business community that, because of the free rider problem, those employers should have to pay into some Charity Care fund to help reduce the burden on the rest of the population, including their competitor businesses that are doing the responsible thing and providing health coverage for their employees. Where do you stand in the notion of some sort of pay-or-play mandate?

MR. WOWKANECH: I'm firmly -- I hope I didn't -- I'm firmly for play or pay because, for my particular industry and the million people that I represent, we're going to go out of business, too, just like the hospitals. We are now uncompetitive. Whether it's the construction industry, whether it's within the hospital situation where now they're selling -- they're going public-private and they're selling. First thing they do is they come in and they tell our people, "You got to take a cut. We're going to reduce your health-care costs. We're going to give you health care, but we're going to cut your package. We're now going to take you out of the State Pension system. We're going to be kind enough to give you a 401(k) and only let you pay into it." So, I mean, this whole thing is a downward spiral.

To me, the only answer is play or pay. But we were at that verge in 1992, and we all know what happened. I also would remind you, Senator, the AFL-CIO sponsored a bill. I think it was called A-4300, sponsored

bipartisan by John Kelly and Assemblyman Joe Patero, at that time from the Labor Committee, a payroll tax, which was one of the findings of Governor Florio's Commission that was convened by all the brightest and the smartest people within the health-care field. So, no, I'm firmly there, but I also like to be in fairness, because I know that there are some people, particularly small business, that maybe can't afford to handle some of this stuff.

But I really think that, just like the example I gave you about the car insurance, it's incredible. We can say, as public policy people, if you're going to drive an automobile in the State of New Jersey, you have to have insurance when you leave your house to come to work in this hospital this morning. But you don't have to have health insurance. I mean, it's unbelievable. So you just go down to the corner, and they'll take care of you. And let Medicare, Charity Care, Tom Terrill, somebody else pay for it -- Who cares? -- as long as you're all right. But I think it's ridiculous.

SENATOR ADLER: The problem you put--

MR. WOWKANECH: If you're a business concern-- This is the other side of it. If you don't want to pay, maybe you want to give them the option. You don't want to pay, fine, but in the event one of your employees end up in one of our hospitals, then you have to pay into the Charity Care fund because you just can't free ride the system. I don't know if you like that.

Senator Sinagra's version is to slowly, incrementally come in with those people who are applying for EDA loans or government assistance, you know are not going to get any unless you have health care. But if you really want to straighten it out and put sufficient money into the system to bring the staffing levels back up in the hospitals, play or pay is the only way to go.

SENATOR ADLER: I think what you're saying really is everybody in the state now has health insurance, every single person, just some of the people aren't paying for it.

MR. WOWKANECH: That's right.

UNIDENTIFIED SPEAKER FROM AUDIENCE: Including State government.

MR. WOWKANECH: I'm sorry I went over the 10 minutes, Senator.

SENATOR SINAGRA: That's okay. Write it down, demerits for Charles. (laughter)

SENATOR VITALE: I just want to get back a moment to your comments about KidCare and Family Care. While KidCare now has increased the eligibility to 350 percent of poverty level, the proposal for Family Care is to provide up to 200 percent to the parents of KidCare recipients, essentially. I think we'd all agree that if these programs weren't in place that literally tens of thousands of children that are covered by KidCare-- I mean, you can imagine the burden that would be placed on hospitals in terms of emergency room visits and primary care physicians or ERs being used as their primary care source.

I think, obviously, we tried to sort of step into the breach and provide for children. I think it is the right thing to do, not just morally, but ethically and for every other good reason. And I think, is it your point that government at some level ought to provide for a greater incentive to businesses, small business in particular, that won't provide or cannot provide health-care

coverage for their employees and their dependents -- car washes, 7-Eleven, McDonald's, Bradlees, whomever--

MR. WOWKANECH: Yes. Yes.

SENATOR VITALE: --and in what way? There is some legislation out there that would provide for some incentives, underwrite the dependent coverage for employees, at least their share of the contribution or a 50-50 match.

MR. WOWKANECH: Yes.

SENATOR VITALE: The employees would get part of their or all of their premium underwritten by the State. But again, the employers have to step into the game and say, "Well, we'll pay for at least for half of the policy."

MR. WOWKANECH: Right.

SENATOR VITALE: You can't put the burden on the employee, obviously.

MR. WOWKANECH: That's right. Right now, without that 50 percent match, to use your phrase, the incentives are absolutely going the other way, as Tom Terrill has said, is that, and I've said, free is better than affordable. I mean, it's really that simple. The incentives are why should we do anything because we're going to get it. Until someone decides that this has to be changed and there has to be reverse incentives, so to speak, for companies to pay for their employees, this is just going to continue to get real bad.

SENATOR VITALE: I guess that in all of that, too, there also has to be a baseline--

MR. WOWKANECH: Coverage.

SENATOR VITALE: --coverage. I have a real problem with bare-bones auto insurance policies that provide really nothing for very little, and that's not a news flash. If you're not paying for a lot, you're not going to get a lot.

MR. WOWKANECH: No. I only offered that-- Again, on the record, I fought it and was opposed to it. That was part of it. But again, in the '92 dilemma, the business community-- And again, I mean the record speaks for itself. I can bring you copies of their testimony. The record speaks for itself loud and clear. Their cry was, "We needed something affordable." So we came out with a \$1000 policy, then we came out with four other policies that went from mid-range to the best coverage money could buy. The only policy that didn't sell and still has not sold today is the bare bones. And yet, some of the business community, or this same group that is now going to say we can't have mandates and we can't have these incentives, is going to tell you that things are just as they were in 1992, unaffordable. But really, as long as they're unaffordable but free, we're going to be discussing this four years from now with a lot less hospitals in our state open.

SENATOR SINAGRA: Thank you, Charlie.

MR. WOWKANECH: Yes, I know.

SENATOR SINAGRA: Thank you. (laughter)

Edith Behr.

JAMES MCGARRY: Good morning, Mr. Chairman. Mr. Chairman, members of the Committee, my name is Jim McGarry. I'm the Director for Governmental Relations for the Department of Health and Senior Services in Trenton. With me is Edith Behr. Edith is the Executive Director for the New

Jersey Health Care Facilities Financing Authority and will provide her testimony this morning. In addition, Mr. Chair, we have copies of the executive summary of the report of the Advisory Commission on the hospitals, as well as an executive summary of the PricewaterhouseCoopers assessment of the financial condition for New Jersey's acute care hospitals.

We appreciate the opportunity to appear before you this morning and speak to these important issues. With that, Edith.

EDITH F. BEHR: Mr. Chairman, members of the Committee, thank you for the opportunity to testify this morning and to convey the fiscal condition of the state's hospitals. As Jim said, my name is Edith Behr. I am the Executive Director of the New Jersey Health Care Facilities Financing Authority. I'm also the President of the National Council of Health Facilities Finance Authorities. The New Jersey Authority was created in 1972. It's the State's primary issuer of health-care revenue bonds and has issued \$9.6 billion in securities, \$4.5 billion of which is currently outstanding. The vast majority of these bonds has been issued to benefit acute care hospitals in the state.

New Jersey has not been immune to the extraordinary pressures felt by the health-care delivery system nationwide. All Americans are experiencing a complete transformation of the health-care delivery system and the way in which health-care services are being paid. These changes have a dynamic impact on the utilization, revenues, and expenses of the facilities for which the Authority provides access to capital.

Before I launch into the fiscal condition of New Jersey's hospitals, it might be helpful to describe the system as it is currently. There are many ways of counting hospitals in New Jersey. Several people have said there are

82 hospitals in the state. There are actually 92 separate acute care sites in the state right now. These are operated by 51 hospital corporations. Sixteen of the hospital corporations belong to in-state hospital systems, 5 belong to out-of-state hospital systems, and 30 are independent. By comparison, at the end of rate setting in 1992, there were 97 sites operated by 82 corporations, 9 of which were part of in-state systems and only 1 of which was part of an out-of-state system. Seventy-two hospitals, at that time, were independent.

So, as you can see in New Jersey, we have had some consolidation. We have a little bit more presence of out-of-state systems currently, but we've experienced very few closures of actual acute care facilities.

Now on to the fiscal condition of the hospitals. Governor Whitman took immediate action in response to concerns raised about the financial deterioration of New Jersey's hospitals. In February of last year, she issued a directive instituting a three-pronged approach to address the concerns. The Governor directed the Department of Health and Senior Services to create a Hospital Assistance Unit, which has been referenced here today, to marshal the resources required to help struggling facilities. She also requested that the Authority commission an independent analysis of the fiscal condition of the State's acute care hospitals. That's the PricewaterhouseCoopers you've heard referenced many times today. And she created the Advisory Commission on hospitals chaired by the Commissioner of Health and Senior Services.

The independent study, which as I said, was prepared by PricewaterhouseCoopers and released in June of 1999, compared the performance of New Jersey hospitals to national and regional benchmarks.

While it compared various groups of hospitals within the state to other groups of hospitals within the state, no individual hospitals were identified.

The study, utilizing data from 1993 through December 31, 1998, confirmed the Authority's own observations regarding the financial deterioration of the state's hospitals. Actually, the study found that the financial performance of the state's acute care hospitals was strong during the first three years of deregulation. That would have been 1993 through 1995. But, as had been said many times here today, the fiscal condition began to deteriorate in 1996, and that deterioration accelerated through 1998. All New Jersey hospitals lost ground to national and regional benchmarks during that time. However, the declines in the absolute levels were found to be worse at inner-city hospitals.

Gary Carter quoted operating margins earlier this morning. By the end of 1998, more than half of the state's hospitals had lost money on a bottom-line basis. Net profit margins had dropped to a negative 0.23 percent, down from a positive almost 2.25 percent for 1997, and composition of that margin had shifted to a greater reliance on investment income rather than income from operations. These trends continued in 1999. Based on information through September 30 of 1999, which is the most recent period for which we have information on all of the state's hospitals, margins dropped even further to a negative 0.68 percent. That's unaudited. In addition, cash reserves are falling at a rapid rate.

The PricewaterhouseCoopers study identified several contributing factors for the financial deterioration. The single most alarming finding of the PricewaterhouseCoopers study was that the average length of stay for Medicare

patients in New Jersey hospitals exceeded the national average by 1.6 days, as of December 31, 1998. According to PricewaterhouseCoopers, this excessive length of stay cost New Jersey up to \$600 million per year -- cost the hospitals. Outpatient revenues had increased, but the growth of outpatient revenues had not matched the regional or national benchmarks. Full-time equivalents -- people, staff -- per adjusted occupied bed were increasing faster than national and regional benchmarks. Federal payments under the Medicare program were reduced by \$1.8 billion cumulatively over a five-year period, and as a result of the Balanced Budget Act of 1997, managed care continued to expand.

The study also pointed out that the State had already taken some actions to support New Jersey hospitals, including the passage of a permanent Charity Care solution at the level of \$320 million per year; appropriation of \$203 million for hospital relief, including moneys matched by the Federal government; promotion of partnerships between urban and suburban hospitals; expedited decisions by the Department of Health and Senior Services on hospital mergers, consolidations, conversions of use, closures, which require a certificate of need; and refinancing of debt by the Authority, resulting in savings of more than \$54 million on a present value basis during 1998 alone.

Senator, would you like a cup of coffee? (laughter)

SENATOR SINAGRA: No, thank you. (laughter)

MS. BEHR: The PricewaterhouseCoopers report--

SENATOR MATHEUSSEN: That's the first time I've ever heard a witness ask you that, Jack. (laughter) It's very nice.

MR. McGARRY: We do our best.

MS. BEHR: The PricewaterhouseCoopers report was distributed to the Hospital Advisory Commission, which was chaired by the Commissioner of Health and Senior Services, Christine Grant, and included representatives of all health-care constituencies. Many of those representatives you've heard here today.

During their nine months of meetings, the members of the Commission reviewed numerous papers and heard from several national experts concerning the similarities and differences between New Jersey and the nation regarding the length of stay, effects of mergers, charity care, and the impact of subacute legislation limiting length of stay.

The Commission determined that the primary cause of the financial deterioration was excess capacity, with 50 percent of licensed beds and 33 percent of staffed beds in New Jersey empty on any given day. The Commission also asserted that it would be much more efficient for entire facilities to close rather than for existing facilities to continue operating fewer and fewer beds. Other factors contributing to the deteriorating financial condition were grouped by those which could be addressed by hospitals themselves, referred to as internal factors, and those which were not under the control of hospitals, referred to as external factors.

The internal factors cited by the Commission included the following: High length of stay -- we've heard about that one already; staffing levels of 4.73 FTEs per adjusted occupied bed in New Jersey, which are 3.7 percent higher than the national median and 12.6 percent higher than the mid-Atlantic region -- I can understand Tom Terrill's sensitivity to this issue because high FTEs were found to be more of a problem at teaching hospitals

than at other hospitals; insufficient information at management and board levels, including understanding changes in the health-care markets, understanding the profitability by payer or product line, ability to track costs, and valuing accounts receivable.

The external factors cited in the Commission's report include the rise in the penetration of managed care from 5 percent in 1993 to 30 percent in 1999; combination of managed care pressures on length of stay and per diem rates; an increase in the number of medical denials by managed care companies; increased competition between facilities, leading to downward pressure on prices; the failure of two HMO plans which have now been addressed by passage of -- and we have Guaranteed Trust Fund in the written testimony, but it's actually the New Jersey Insolvent HMO Assistance Fund Act of 2000; negative impact of the Balanced Budget Act of 1997; Medicaid rate reductions in the mid-1990s, as it sought to become a prudent payer; lack of alignment between physician payments and hospital payments under the Federal Medicare program, with hospitals paid on a per case basis and doctors paid on a per diem basis.

The report stresses that many groups have a role to play in the stabilization of the State's health-care system. Hospitals must reduce their length of stay and their costs, get people enrolled in Medicaid, New Jersey KidCare. Physicians must recognize the need to reduce the length of stay. Trade associations and providers must educate consumers that even with fewer acute care facilities, the necessary care and treatment they require will be available.

The Advisory Commission report made a substantial number of recommendations for State action. They fell into three distinct areas: First, promote the transition to an appropriately configured health-care system; second, ensure that reimbursement levels are fair; third, resolve payment issues.

The Advisory Commission on Hospitals delivered its recommendations to the Governor on November 23, 1998. The administration has taken a number of actions to address those recommendations. New Jersey hospitals can expect to receive \$629 million in additional revenue over the next 16 months as a direct result of Governor Whitman's budget proposals and lobbying efforts in Washington and the Federal government's recent ruling on Medicare disproportionate share reimbursement.

Hospitals will benefit from revenues derived from the following five initiatives: \$30 million in supplemental Charity Care payments; \$80 million through the Governor's Family Care proposal; \$54 million from HIP-APPP reimbursement; \$365 million in Medicare DSH payments for Charity Care days; and \$100 million in Medicare DSH payments for Medicaid managed care days.

The State's response also includes significant progress in implementing several additional recommendations from the Governor's Advisory Council on Hospitals: Medicaid managed care periodic interim payment for distressed hospitals; simplification of documentation for emergency room Charity Care patients; ongoing research by a prompt-pay study group; and creation of a hospital asset transformation program.

Mr. Chairman, members of the Committee, the financial difficulties confronting the state's acute care hospitals are significant. But I am proud to say that New Jersey has recognized this situation and has taken quick and thorough action to alleviate roadblocks and to facilitate a smooth transition of the State's health-care delivery system into the 21 century. In fact, after a series of briefings by Authority staff, representatives of the municipal investor community and municipal bond rating agencies told us they were favorably impressed by the aggressive manner in which this State is attempting to resolve these issues. If all stakeholders work together, we can implement solutions and guarantee that the citizens of New Jersey will continue to enjoy the benefits of having financially viable health-care institutions dedicated to their health and well-being.

I would be happy to answer any questions.

SENATOR SINAGRA: Thank you.

Yes, Senator Adler.

SENATOR ADLER: Thank you, Ms. Behr.

I'm sure Alex Hatala and Tom Terrill -- and I know Les Hirsch is here, and Rich Miller is here -- I'm sure they're delighted to hear about the quick and thorough action that the administration has taken. I'm sure that has, at this point, relieved all the concerns that they might have in terms of affordability and profitability and survivability for all their hospitals. So I'm delighted to hear that.

Maybe you could give me a report card on the administration's overall handling of health care. What would the grade be?

MS. BEHR: Well, compared to my colleagues around the State, I'd say we're getting an A right now.

SENATOR ADLER: We're getting an A. That's good. With about half our hospitals running in the red, we're doing pretty well?

MS. BEHR: The hospitals are private institutions, and they do have serious problems. I can tell you, as executive director of the Health Care Facilities Financing Authority, we do have bonds outstanding on behalf of most of the hospitals around the state. We keep very close track of the financial condition and do go out and talk to -- in response to your comments earlier, Senator Vitale -- we do call to their attention, even if they're not aware that they are experiencing some kind of financial distress. There have been resources put together at the Department of Health and Senior Services. I know my staff have been very helpful to many institutions around the state. Ultimately, it is a joint effort. The State cannot solve all of the problems for all of these privately run institutions.

SENATOR ADLER: Don't we really have to look at results, look at outcomes? If unemployment is very, very high, the Governor can't go around bragging that he or she is doing a great job with economic development in a state or in a country -- for president. Here we've got 19 percent, 19.5 percent, 20 percent uninsured. Is that about the right number right now?

MS. BEHR: I'm not-- I don't know what the percentage is.

SENATOR ADLER: I think it's higher than-- Charlie Wowkanech said 16 percent. I think it's around 19 percent, 19.5 percent.

MR. TERRILL: About 18. (speaking from audience)

SENATOR ADLER: Eighteen.

MR. McGARRY: If I may?

MR. TERRILL: It's the second fastest growing state in the nation.

SENATOR ADLER: That's a proud accomplishment, okay.

MR. TERRILL: Yes. Right behind Texas.

MR. McGARRY: If I may, through the Chair?

SENATOR SINAGRA: Surely.

MR. McGARRY: Senator, I think it's important to recognize here that this is a period of transition, not just for hospitals, not just for outpatients, but for the system as a whole. I don't think anyone is going to represent that situation is where we all want it to be right now. Certainly, I think the Department of Health has been very proud to work with members of the Legislature, Senator Sinagra, Senator Vitale, Senator Matheussen, and you, Senator Adler, on good legislation that's designed, over time, to address the needs of the people of this state. Are we where we want to be right now? I think the answer is not just yet, but I think the important thing is that we're making good strides and going in that direction.

Thank you, Mr. Chairman.

SENATOR ADLER: Let me talk more about Charity Care for a second, because I'm-- Is that all right?

SENATOR SINAGRA: Sure, if it's a question.

SENATOR ADLER: Because I really have an ongoing concern that while we, I think appropriately, should put more money into Charity Care this year and next year, both to change the formula to make sure that Our Lady of Lourdes and Virtua and Kennedy get their fair share without depriving Cooper and other urban hospitals that have a disproportionate percentage of

Charity Care, I'm concerned long-term that we've reduced Charity Care so that the need is reduced so that the burden on the hospitals and doctors is reduced.

KidCare so far has really not had an appreciable impact yet on reducing the Charity Care needs for children in the state. I think you'd agree with that, even though there are some encouraging recent signs, it's still much, much less successful than we hoped it would be. Would you agree with that?

MR. MCGARRY: Through the Chair, Senator, I'm not going to hold myself out as an expert in -- either in Charity Care -- it's a very complex issue -- nor am I going to suggest that I'm the ultimate word on things like Family Care and KidCare. And certainly, our colleagues at the Department of Human Services would probably be a better source of information. Nevertheless, I think the-- Again, bearing in mind this is an evolving picture, I think the growth and enrollments in KidCare, the plans for Family Care, are steps in the right direction, and these are good. This is a good bipartisan initiative, and I think that, over time, you're going to see that it is going to have a great beneficial effect with respect to the health-care system as a whole, and particularly with respect to the need to better manage issues like Charity Care.

SENATOR ADLER: Well, it's certainly a nice idea, and it certainly sounds nice politically, but we know, statistically, Mr. Terrill said it again, Charity Care is growing. It's not shrinking. More and more people are going without insurance for a variety of reasons. I guess what I'm hoping is the administration can give us some leadership or some guidance for us to follow, so we don't have a veto of something that we pass, with good intentions, on

ways to encourage those employers of the 70 percent uninsured who have jobs. And maybe they're jobs working at Wawas or gas stations or pizza places or maybe they're free riders at a higher level, but wherever, how do we get those folks insured so that we reduce the burden on the hospitals represented here and represented by their counterparts throughout the state?

MR. McGARRY: Through the Chair, Senator, I think at this point I'd probably have to defer to some of the real experts in terms of how you build enrollments in good programs like KidCare and Family Care. In terms of working with the Legislature and in taking real leadership in this regard, I think the passage of Senator Sinagra's recent legislation is an example of the kind of legislation that is going to be needed in the years to come. I think that really defines good leadership -- the administration, the Department, working with the Legislature.

Thank you.

SENATOR ADLER: I'm still sort of grasping. You heard Senator Vitale earlier suggest that we should find some incentives to encourage small businesses in particular who are not providing health insurance to provide coverage for their employees. You heard Mr. Wowkanech, with a little prompting from me, suggest that maybe a mandate might be the appropriate way for those employers who are free riding the system and shifting the costs to other employers and to taxpayers. What sort of guidance can you give us for either incentives or mandates that the administration might support that would help us substantially reduce the Charity Care burden that's facing the hospitals and doctors in our state?

MR. McGARRY: Through the Chair, Senator, that's a very complex issue, and I'm not going to suggest that I'm here to represent the administration. I'm here from the Department of Health. There are many elements to the problems as well as many important views -- groups that are important players in this overall question. I'm sure that in the near future you're going to find a good commonsense approach to that. But again, I'm not going to represent that I'm the best person to represent that.

Thank you.

SENATOR ADLER: Well, I'm sort of baffled by that. You're the government relations person for the Department of Health and Senior Services for the administration.

MR. McGARRY: Correct.

SENATOR ADLER: Who actually is allowed to talk about health issues? It's not you?

SENATOR SINAGRA: Just one thing, Senator Adler.

SENATOR ADLER: This is a problem spiraling out of control, and if he can't do it, maybe the administration can send somebody who can talk to us.

SENATOR SINAGRA: I understand. I understand. No. No. I don't disagree. But as you know, we're having a series of hearings. They're here to testify as it pertains to their role in the bonding and the health-care facilities. And I give you some broad latitude in the questions, but it's very unfair to ask them here, when they're here to testify on something, to ask them exactly what the Governor's policy is. Now, at some point, what we're trying to do is get to that policy, and maybe we need to set that policy.

The nice part, whether we all hate it and politics is already starting to enter into most of our discussions, because they're-- Unfortunately, everybody gets to witness what partisanship is about. We will have a debate. There will be a new Governor a year and a half from now, and there may be new solutions to some of the problems we have today. I sincerely hope that part of the debate, whether it's the Senate President, whether it's McGreevey, regardless of who it is, this is an incredibly important issue to the people of New Jersey -- just not the hospitals. We're talking about a basic issue here. I truly hope that, in that debate for who's the next Governor, this is one of the key components of that debate.

SENATOR ADLER: Mr. Chairman, I share your sympathies and concerns, but--

SENATOR SINAGRA: But I should say it's a little unfair-- We're pressed for time. It's not like I don't want to give you latitude, but the fact of the matter is it's unfair to ask them some of these questions. In fact, I--

SENATOR ADLER: In fairness to the hospitals and doctors represented here--

MR. MCGARRY: Thank you, Mr. Chairman.

SENATOR ADLER: --they're pressed for survival.

SENATOR SINAGRA: I understand.

SENATOR ADLER: And somebody--

SENATOR SINAGRA: I understand, and that's why we're here.

SENATOR ADLER: --at the administration has to give us some guidance so that when we pass something it won't be vetoed.

SENATOR MATHEUSSEN: And Mr. Chairman, if I could interrupt just a second. Mr. Chairman, that's what this Committee is designed to do.

SENATOR SINAGRA: That's what we're trying to do.

SENATOR MATHEUSSEN: This Committee is designed to go out and hear the testimony of the insurance companies, which we've already done today, to provide us, i.e., the hospitals. We're bound to get the other providers involved, and most importantly, we're going to hear from consumers and what they feel like in this entire crunch. And hopefully, the leadership, if it's not there now and whether it is or not, is not the debate of this Committee, but the leadership will come from this Committee as to what we can do about those problems. But not hearing the testimony of the hospitals and the others is, literally, critical to what we're going to be doing here. And I think we need to hear that testimony, whether or not we want to debate, whether or not there's been leadership or lack of it or what we're doing about it. We're going to do something about it, otherwise then we're to blame.

SENATOR SINAGRA: Another question, John?

SENATOR ADLER: My question is, are we going to get somebody from the administration who can talk to us seriously about what we should do?

SENATOR SINAGRA: I would hope so at some part of this. I will ask, specifically.

SENATOR ADLER: I think, unfortunately, we do-- We all very well know the problems that Senator Matheussen was describing the hospitals

are facing. We are very well familiar with them. We can study this for another year and a half and have a new Governor and that maybe--

SENATOR SINAGRA: We're not studying it for a year and a half.

SENATOR ADLER: Okay. All right.

SENATOR SINAGRA: This Committee will come up with some sort of consensus of what we feel the legislative remedy is. That's as far as we can go.

SENATOR ADLER: I hear you, but that's why we've got to get the administration here.

MR. McGARRY: Thank you, Mr. Chairman.

SENATOR SINAGRA: Thank you very much.

John Gantner.

JOHN J. GANTNER: I'll stick to the 10 minutes because much of what I had to cover has been covered in one way, shape, or form. So I'll try to stay out of the statistics.

SENATOR MATHEUSSEN: You can use less if you need to.
(laughter)

MR. GANTNER: My name is John Gantner, and I'm the Treasurer of Robert Wood Johnson University Hospital in New Brunswick, New Jersey. I want to start by thanking you for the opportunity to be here this morning to share my perspectives on the challenges that are facing the New Jersey acute care hospital industry. I've been involved with the New Jersey hospital industry for about 25 years, most of that time as a consultant with a Big Five firm -- actually, it was a Big Eight firm when I started, that's how long ago -- most recently, as a member of hospital administration. The system has

operated under intense regulation for most of that time, but as we all know, for the last seven years the system has been deregulated.

Throughout my 10-year exposure to the system, I've seen hospitals go through good times, some not-so-good times, back to good times, some not-so-good times. However, in my observation, the seriousness of the industry's present situation is absolutely unprecedented. This is a true change. This is a landmark time in terms of the New Jersey hospital industry. It's very, very serious. I understand that the purpose for these hearings is to help the Committee members understand the issues, the problems that are facing hospitals and creating the current dilemma.

There are numerous issues that have been cited and discussed, and it, frankly, gets very complicated, and I don't envy this Committee in having to disseminate the information and try to make sense out of it. However, from my perspective, I believe there really are a couple of central issues that underpin or really create some of the other situations that get discussed. I think it's important to distinguish between the factors which are truly driving the crisis that's going on right now in New Jersey, what I'll call the root causes, and to distinguish those root causes from some of the symptoms that have evolved as a result of those root-cause problems.

Reform won't occur in our system if we only treat the systems. True reform will only occur if we get to those root causes and fix them. I see two root-cause problems, major root-cause problems, in the State of New Jersey. One is the need for insurance reform. That was discussed very well earlier today. There's too many people. There's an increasing number of people taking a free ride on the health-care system, and it's absolutely starting

to take a toll. We've seen dramatic increases each year in our uninsured patient base, and it's inconsistent with the true poverty level in our area.

The root cause that I want to focus on, the second root cause, in my opinion, is the oversupply of hospitals and hospital beds. I'll spend a little bit more time talking about that. The statistical benchmarking data that are commonly cited as reasons for the lackluster performance of New Jersey hospitals, including lower occupancy rates, high unit costs, high lengths of stay, and staffing levels, are to me not the central problems. They are the symptoms that are associated with the marketplace that is overhospitalized and overbedded.

Reduce the number of hospital facilities in key New Jersey markets, and the redirected volumes will improve the benchmark performance of the surviving hospitals. It's not a pleasant subject to talk about. It's very difficult to talk about. It's harder to implement and see it happen. But I believe unless we reduce the supply of hospital beds, and do that through reducing hospitals and reform insurance at the same time, that we'll never really cure the problem and will create a system that needs a lot of financial subsidy in order to stay alive.

There are two specific circumstances that are germane to New Jersey which exacerbate the situation of the oversupply of beds. I think the most significant of the two -- and the two are the subsidy payments that are made in the State and the quickness with which New Jersey moved from a regulated State to a deregulated State.

Let me start with the subsidies. They've been discussed at some length here today. There really is about \$500 million worth of subsidy

payment that flows each year to New Jersey hospitals -- 320 million, as we've talked about, for Charity Care and another 183 million for the hospital relief fund. I have to be careful as I cover this topic, because I'm not for a moment suggesting that we should reduce or eliminate the subsidy funds. They're absolutely needed. I think New Jersey can be extremely proud of its track record in the DRG system and, subsequently, its track record of making health care available to every patient regardless of the ability to pay.

The problem, and we heard it earlier today, has to do with the formulas that are used to distribute those funds. That's one problem because the formulas are unfair. The other problem is we are in a deregulated environment, and we're in that environment, for among other reasons, to allow the marketplace to act on the health-care system and, hopefully, rightsize it. Any time you have a deregulated marketplace and yet that marketplace includes subsidies, we had to be very, very careful about how those subsidies are distributed because they have the potential to interfere with market forces that could be healthy for the environment.

So I think my message, with respect to subsidies, is not getting into whether the amounts are sufficient or insufficient. It has to do with the equity and the distribution of those moneys and their potential negative impact on the marketplace. In an overbedded market, the subsidies which are really earmarked for Charity Care could actually be keeping hospitals open that otherwise wouldn't be open. And if we agree that excess capacity is part of the root-cause problems in the New Jersey marketplace, we're actually investing in our own problems, and that's not a situation that we should be involved in.

The second New Jersey-specific complicating factor is the speed with which we moved from regulation to deregulation. New Jersey operated for over 20 years in a very regulated environment, and regulations cause the hospitals to act in a certain way. They absolutely insulated us from market forces. They greatly encourage capital investment because, under the DRG system in particular, investments in bricks and mortar were automatically passed through the hospitals' rates. So there was encouraging to expand and update the hospital facilities.

The regulation also discouraged the subacute facilities and alternate level of care facilities, because the way the hospital rates were struck under the DRG system, they included all the costs of operating the hospitals in the state, and that included cost for subacute patients. So there really was no compelling reason under the DRG system for hospitals to seek out -- were no financial incentives, necessarily -- to seek out alternative levels of care. Then in January 1, 1993, that all changed, and the hospital industry entered a very unfamiliar and hostile environment, one of deregulation. We're now struggling with the vestiges of our prior regulated system, including excess capacity, high fixed costs, and lack of alternate level of care facilities.

We need to recognize that some of the pain we're experiencing is a natural consequence of moving to a deregulated marketplace. The reason the pain is so great is because we moved abruptly into that deregulated marketplace. So we need to do some things to ease the transition, certainly. And at the same time, the hospital market is not making widgets. We can't afford to allow all hospitals to go out of business in a haphazard manner. There are, absolutely, hospitals whose personal economics would not support

those hospitals staying open, and that's where the rational system of subsidies really -- not only is it important, it's absolutely essential to our health-care system.

Then there are other factors that are complicating the situation in New Jersey on top of the factors I've already mentioned. The Medicare Balanced Budget Act is very hurtful to hospitals. On top of that, the transition to an increasingly managed care marketplace is harmful to hospitals. Medical denials are huge. In 1999, Robert Wood Johnson wrote off about \$5 million related to medical denials. We had some payers that were denying close to 20 percent of the days of care that occurred in our hospital. So that's an area where we, as an institution and I think as an industry, need some help.

The question starts to boil down to what is the right amount of government in terms of impacting on our health-care system. And it's not an easy question to answer. Certainly, constant and continual government involvement is necessary in our health-care system, certainly in the area of funding for indigent care and protecting access to care for those who can't afford it. We believe government's important also with respect to protecting, under certificate of need regulations, certain tertiary and quaternary services for quality purposes where the data clearly show that more cases rendered equals better quality in the cases that are handled. And we need the State to be involved on an ongoing basis in licensure-inspection type of services. Also, in a downsizing marketplace, government has a role in terms of the transformation and transition of facilities to alternative uses or potentially even to just outright closure.

In summary, the central issues affecting -- undermining the economics, I should say, of the New Jersey marketplace are excess capacity and the need for some insurance reform. Any attempt to assist the struggling industry right now that does not address the capacity issue is at best a mandate. I mentioned also earlier that the abrupt transition has worsened the situation in New Jersey hospitals, compared to some other marketplaces. And I also believe that the subsidy system in New Jersey must be preserved and continued, but it has to be corrected, compared to the system we have today.

I thank you for your time this morning, and I'd be happy to answer any questions that you might have.

SENATOR SINAGRA: Any questions?

Senator Vitale.

SENATOR VITALE: Thank you.

I want to, just for a second, talk a little bit about hospital closings that you addressed in your comments. If certain hospitals were to close, then that would certainly move some of those patients to other hospitals to sort of build them up and increase their bottom line. It would solve the nursing shortage in New Jersey. Maybe it would solve some other problems, which I don't mean, but--

MR. GANTNER: It solves problems and it creates problems. I understand that.

SENATOR VITALE: Well, it does. I just think that-- I mean, I'm a big fan of hospitals and a big fan of providers. I've got to just sort of take a step to the side and say that -- concerned with the way in which so many of us

-- another sort of cavalier approach to suggesting that hospitals ought to close. It's like hospitals and the people that they serve are the victims in all of this.

MR. GANTNER: Right.

SENATOR VITALE: Instead of looking at the reasons why these hospitals are closing and have a complete picture of why they're closing, whether it's downward pressure of a managed care or it's a length of stay issue, it's all these other things, external and internal factors, to go to the end of the line and say, "Well, if we close hospitals, some of those hospitals, and help build up some of the others, we haven't still addressed the reasons why these hospitals have gotten into the position that they are in today and done it honestly." I'm not so sure that you're advocating this, but that we have -- how many counties do we have in New Jersey?

MR. GANTNER: Twenty-one.

SENATOR VITALE: I'm not running for Governor. (laughter)

Twenty-one counties, so that--

That's obvious.

SENATOR MATHEUSSEN: That's a baseline test. (laughter)

SENATOR VITALE: Exactly. (laughter)

What county is this? (laughter)

We have 21 hospitals that are the equivalent of the Home Depot of the health-care industry. We have megahospital centers, and people have to drive miles and miles to get to them. Community hospitals are in trouble, urban hospitals are in trouble, who have the greater share of Charity Care and all that. I just-- We're at the end of the line here. We're at the end of the

argument. We're talking about what-- We need to be talking about what's created these problems.

I'm not so sure that hospital closings en masse or even after five or six or ten or twelve or God knows how many some folks are advocating, that that's going to be the answer. Because at the end of the day when those hospitals close and we have surviving hospitals, whether it's -- whatever the number is, the issues that drove those dozen hospitals out of business are going to continue to exist and be forced upon the hospitals that continue to exist, whether they are teaching hospitals that do well or inner-city hospitals that don't do so well, I guess. And I don't know if there's a question in there anywhere.

MR. GANTNER: Well, I think it almost becomes second--

SENATOR VITALE: I get frustrated when I hear that hospitals close. What the hell, let them close. Memorial closes, good for them. Raritan Bay will do better, Bayshore will do better, but what about an entire community of 50,000 to 60,000 people who don't have any care, don't have access to immediate care or timely care that they're used to? So do you leave a void in the community? So there's all those other issues, but your hospitals and patients are the victims in all of this. They're not the root cause of the problem.

MR. GANTNER: Yes. I hope that not for one minute that I sound cavalier about presenting the closure issue.

SENATOR VITALE: No.

MR. GANTNER: I think it's a difficult and touchy issue and--

SENATOR VITALE: I said we.

MR. GANTNER: --it's hard to talk about and think about. And it almost becomes circular in terms of is the low occupancy the result of too many hospitals or is it the result of other things that -- other problems that are created. The report that was done-- I guess the Advisory Commission report did some projections and estimated that there would be 6000-plus, actually 6200, 6300 excess beds in New Jersey by the year 2002. That would equate to 20 to 30 facilities, if you wanted to look at it a different way.

The report went on to say that there's about a billion dollars worth of cost associated with maintaining that excess capacity and that, through closing facilities in a very simplistic model -- and by closing facilities that billion dollars of cost, which right now is being borne by individuals, employers, and State and Federal government, would fall to the benefit to the net revenue line of the remaining hospitals. Even if they were only half right, that's a huge amount of money. But it is a very difficult and touchy issue, I agree.

SENATOR SINAGRA: Thank you, John. Thank you.

MR. GANTNER: Okay.

SENATOR SINAGRA: Rich Miller.

RICHARD P. MILLER: Thank you, Senator. It's great to be here this morning.

You've heard a lot of the information coming from the hospitals. Hopefully, I won't repeat a lot of that. I will dovetail off of what John Gantner was talking about because I think it's important to understand, first of all, what the mind-set is here, and where we've gone from a regulated environment to a deregulated environment. Because I really believe, in the early '90s, a lot

of that is the cause of where we are today. I want to speak a little bit about that, and hopefully, come back to that at the end.

Understand in the early '90s, when we were under a Chapter 83 rate-setting system, you kind of knew what your revenue stream was going to be in the early '90s. You had set rates. You had case rates that you were given -- was set by the State of New Jersey for all payers, and you pretty knew what your volume was going to be in a given year. You knew what your revenue stream was going to be in a given year. With the advent of deregulation in '93, that changed, and it changed significantly for a couple of reasons.

First of all, remember that hospitals, from a cultural standpoint, had a belief that they knew what the revenue stream was, so they were more or less guaranteed a certain revenue stream. Secondly, they were reimbursed off of case rates, okay, which is much different than what happened in 1993 and 1994 when managed care came really into vogue, and then the reimbursement mechanism changed to per diem rates.

Now day rates and case rates are a totally different methodology in reimbursement for hospitals. Per diem rates from managed care companies mean you're reimbursed per day. Case rates mean you're reimbursed per case. So obviously, we knew at that point that length of stay was a major issue. We knew it beforehand, but we really knew at that point that the length of stay was going to be a major factor in how we were reimbursed down the line.

I think some of the comments earlier about the transition from case rates to day rates, and the transition in our physicians' mind-set and length of stay, had to be looked at across all hospitals in New Jersey. So we were getting the pressure at that point, 1993 and 1994, to do managed care

contracting on a per diem basis. Now, at that deregulation point, we also knew we were in a competitive environment -- no question about it -- much more competitive environment than we ever were before because hospitals now were competing for volume and for physicians to make sure that their beds were filled.

Okay, so what was happening was we were competing for that business. A lot of hospitals, I'll be honest with you, signed contracts back in 1993 with managed care companies that were below cost, on the promises that people were going to ship volume around to hospitals. I mean, I think you've heard this before. We're going to move volume to your hospital if we sign a contract at this per diem, which kind of was an empty promise, okay, because that wasn't happening. Physicians were not moving their patients because they weren't comfortable in moving their patients, and rightfully so. So hospitals back in 1993 that signed the low-cost contracts had to live with those contracts for a number of years. I think we're seeing over the last five years those contracts coming to fruition. They're just about over, and you're seeing a lot of hospitals now renegotiating contracts with managed care companies and being very tough about those renegotiations because they were below-cost contracts initially. That was a major problem.

I also want to state that there wasn't a panacea prederegulation. Hospitals weren't making a lot of money in a regulated environment. I mean, margins were 1 percent, maybe 2 percent, at most, for hospitals around the state. So there wasn't a lot of money. There was low liquidity in the marketplace, high debt for hospitals in the marketplace. So now, as you transitioned into a deregulated environment, all right, that-- The high issue of

high leverage and low liquidity was still there, and now you had to deal with the issues of managed care that presented themselves.

As time went on, the Charity Care issue obviously became prevalent. And to give you an example, Virtua Health is a five-hospital system. We have a hospital in the inner city-- We're one of the forgotten hospitals in the inner city of Camden. We also have four suburban locations, one in Mt. Holly, one in Berlin, one in Marlton, and one in Voorhees. I received, for \$12 million of Charity Care at Medicaid rates, zero for treating those patients, and I have a inner-city hospital that I have right now. I want to speak about Camden in a minute, which is critical to this.

Charity Care is a major issue for us. I can tell you that. When we passed the legislation a few years back to allot the \$320 million statewide-- I think Senator Sinagra used-- I don't have any parking spaces either. Maybe that may be my problem. But how that regulation was promulgated and how the money was distributed is based on such an antiquated formula, it's ridiculous. And I went in front of the Senate Subcommittee back three years ago, when everybody was euphoric about \$320 million, and said we got to look at the distribution of those funds. I think people were happy, and I congratulated the Legislature for providing 320 million, but the distribution formula was never looked at. The problem is hospitals-- Even if we have a suburban base, and I have a hospital in Mt. Holly that does quite a bit of Charity Care -- needs Charity Care money to support ourselves. We need to distribute those moneys more fairly, and we need more moneys in the system. And you've heard that, and I'm not going to dwell on that, but that's a key issue for us.

The Balanced Budget Act, obviously, is a major issue for us as well. Look at a system that was instituted in 1997 that has disincentives on the inpatient side and disincentives on the outpatient side. So when we moved patients through the inpatient system and they go to outpatient, they go to home health, we're limited on home health visits and how many visits we can see our patients at home. We're limited to about two to three visits, home health visits, per Medicare patient right now. That's not enough to provide quality care in a system that forces lower lengths of stay and forces patients out of the inpatient system. You need to balance the incentives in the system, and you need to balance them more on the outpatient side. I know that's a Federal issue, but it's a major issue for hospitals as well.

I want to thank the Senate and I want to thank the Assembly for the issue around HIP in New Jersey. Virtua Health had a problem of \$7.5 million with HIP, and we appreciate the help we got in that area, because that was a major problem for us. We saw a write-off of approximately \$7.5 million for HIP. That issue helped us to quite an extent.

Understand on the expense side as well -- there are expense issues. I touched on a lot of the revenue issues. Oh, on the expense issues, we're an industry that's about 60 percent labor. We're a highly leveraged labor component in our expenses. There is no business that can operate like health-care businesses because two days ago one of my hospitals saw 80 patients. Today that same hospital has 120 patients in there. Try to balance staffing. How many businesses need to look at-- Most businesses can fix their labor component based on revenue stream, knowing what their revenue stream is projecting -- a fairly stable revenue stream. We don't have that luxury. So

we're constantly looking at how many nurses do we need on the floor? How many technicians do we need on the floor?

It creates a major problem for hospitals when we have to fluctuate day to day on census. And I'll tell you, we have a lot of single parents that work in our industry. It's very difficult for us to tell them that we don't have enough patients in the house today to have you come to work. It's an extremely difficult balance for us right now. We're trying to balance that, and we're trying to keep people working.

And especially, look at Camden. The three hospitals in Camden are the major employers in that city. It's a very fine balance right now. And when you have to bring agency nurses in to cover floors and you're using a lot of overtime, it becomes very difficult. We want to keep our employees and our nurses and our technicians employed in all of our hospitals. That's very important.

In closing, what's the things we need to be looking at. I agree with John Gantner, to some extent we're overbedded in this state. There's no question about that. We're supporting a lot of bricks and mortar in this state in terms of beds.

Senator Vitale, I don't disagree with you. That's a very hard issue to grapple with, and I'm not saying that's the answer to our problems. It may be part of the answer to our problem. But I would suggest to you that-- For example, in Camden, I have a Camden hospital that I've already discussed. It's been out in December. I've talked to my employees that we're going to have to at some point close our inpatient unit in Camden. We've already had that

discussion with our employees. I've had that discussion with various legislators, and it's not an easy discussion to have.

Because as I've said, when you have three hospitals that are the major employers in Camden inner city -- we're it -- to take one employer out of the mix is difficult. What we're looking to do is to transition that hospital, not close it, but transition it to other types of services that the city needs.

I went up and talked to the Commissioner of Health about that. I'd love to be a pilot hospital in this process to see what we could do in providing some dollars to help that transition happen. I'm willing to do that, but with debt service we're carrying in that hospital, with transitional costs that need to be handled in that hospital, it's going to be very difficult for us to do in transition. We're over 200 beds licensed in that hospital. We're seeing about 30 to 40 patients on average right now. You can't operate a hospital efficiently doing that. And we're looking to the State of New Jersey and we're looking to the Commissioner's Office to say, "And here are some incentives to do this. We'll help you do this, and we want to provide some opportunity for you to do this and transition Camden, whether it's into a substance abuse services, which are needed in the inner city, whether it's into adult day care, whether it's into adult senior housing, those programs that are needed in the city. We're willing to do that." We need some support to do that.

As long as we're in a deregulated, competitive environment and as long as there are as many beds as there are, we're going to see these types of significant problems. I will also tell you that, in terms of reporting our costs and reporting our issues, we're one of the most regulated industries in the world. Our books are open to everybody. They're open to the State. They're

open to the government. So I just want to point out, an earlier speaker had said we'd like to see these things. We're more than open to sharing. We share them now, and we share our cost reports. We're willing to share that information with anybody that would like to see it.

Maybe there's an avenue-- I've talked to Senator Adler -- about our Medicaid laws in providing more access to Medicaid, opening up the Medicaid regulations to some degree to provide more access for Medicaid. There may be some things there we can look at. I'm having our people look at that right now to see if we can provide more of that. And maybe there's a way to provide small business on a pro rata basis, have them contribute something based on the size of the business, because you don't want to burden business, but maybe on a pro rata basis on the size of their revenue to provide some relief for Charity Care or insurance as well. There may be some things legislatively, governmentwise, and having business partially support that we can work together and do this.

I'd be happy to answer any questions that you may have.

SENATOR SINAGRA: I just have one question, only because I asked Gary Carter the question, and your testimony brought it back to me. Do you feel there is any correlation between the financial health of some of the hospitals that are in jeopardy now and their occupancy rate -- only because when you just said that about your occupancy rate in your hospitals?

MR. MILLER: All right. There is because--

SENATOR SINAGRA: Because he basically told me there's no correlation between the--

MR. MILLER: No, there is. There absolutely is, because in most hospitals you're carrying fixed overhead to support your patient load. For example, it's just not looking at a patient care unit. It's looking at a radiology department. It's looking at a physical therapy department to support that. It's talking about an outpatient clinic to support that. It's a domino effect. So, if you have inpatient care in your hospital, you have ancillary support and other types of support, overhead support, to support that inpatient care. So there is a correlation.

SENATOR SINAGRA: Thank you.

John.

SENATOR MATHEUSSEN: Just a couple of things. I want to compliment Rich on a couple of things. First of all, the Charity Care. I do recall, three years ago, him being very happy and saying that about the amount of Charity Care, but warning us at the very beginning that the formula needed to be looked at. The Charity Care formula needs to be, obviously, overhauled and reflect today's issues, not 10 years ago issues. I think we need to do that. And hopefully, as a result of these Committee hearings, that's one of the things we will do.

The other thing is, too, the outreach that Virtua is doing with regard to outpatient services. You're telling me that you're not getting the reimbursement, though, from Medicare on those services, but yet you're doing a lot more and more of that.

MR. MILLER: Right. Let me touch on that, John, because that's a valid point. Not only the outpatient services, clinical services that we provide -- and I'm glad you brought that to mind, because I wanted to touch on that --

it's the community education that you provide the community. I have school systems right now coming to me saying, "We want you to come in and support us in the areas of teen pregnancy and teen sexuality and teen smoking in our middle schools and in our high schools which are health related." If we don't have the funding to do that, we're not going to be able to do that, quite honestly. And we're supporting that right now. We're doing that.

SENATOR MATHEUSSEN: And that funding source traditionally is both Federal and State?

MR. MILLER: Yes.

SENATOR MATHEUSSEN: Okay.

MR. MILLER: Yes.

SENATOR MATHEUSSEN: And the other thing is, Rich, I think that the explanation of a pilot program in Camden is one that's going to be a reality, and I know that you've talked about this and we'll be meeting with the Commissioner. And South Jersey will certainly look forward to, I think, piloting something down in Camden and making good use of the facility that is not being utilized to its point right now. I think that's going to become a reality.

MR. MILLER: Thank you, John. I appreciate that.

I also want to say, Senator Sinagra, that I appreciate the work of Senator Matheussen and Senator Adler in South Jersey. These two senators have been with us every step of the way in supporting our needs in South Jersey and supporting communities, and we do appreciate that.

SENATOR SINAGRA: Senator Adler.

SENATOR ADLER: I just want to make a comment in response to Senator Vitale's concern.

Rich, I know how much you and people at Virtua really anguished about the possibility of closing the inpatient portion of the Camden Division of Virtua. And sometimes inefficiencies-- You don't have overbedding in the city of Camden, which has a smaller population now than 10 years ago or 50 years ago, certainly. I just want to reassure Senator Vitale that, in fact, you really went through agony before reaching that conclusion. I don't want you to think, based on -- anybody to think, based on the conversation with Mr. Gantner earlier, that it's a casual decision that any--

MR. MILLER: Yes. Senator--

SENATOR ADLER: --hospital makes, not just yours.

MR. MILLER: --first of all, Camden was our original hospital.

SENATOR ADLER: Your home.

MR. MILLER: Our home.

SENATOR ADLER: Right. I want to ask one other question about finding efficiencies in the system, because I heard the administration talk about how hospitals have to continue to find efficiencies. I know that at one point you were talking to a couple other health systems in South Jersey about finding efficiencies at a Cherry Hill hospital site to provide an attraction for heart patients. What happened there and how shall we move forward to find efficiencies in the system and provide new revenues for your hospitals and to provide good health for the people in South Jersey?

MR. MILLER: That's a balance, Senator Adler. I mean, obviously, in a deregulated environment -- I think Gary Carter said it earlier --

some things are still regulated. And for example, in terms of heart surgery, that's a very regulated environment in New Jersey. The problem you have with that, and think I would -- speaking for some of the Camden hospitals who provide heart surgery -- it becomes a problem if you take those issues out of the inner city. We understand that, but there has to be ways to partner hospitals to be able to provide heart surgery in various locations. That's an example in terms of the heart, but there are other services that are regulated that we may want to look at a more of a deregulated environment.

Again, I support that, but I also want to make sure that we don't rip the heart, so to speak, out of some of our inner-city hospitals as well.

SENATOR ADLER: Of course.

SENATOR SINAGRA: Thank you very much.

MR. MILLER: Thank you, Senator.

SENATOR SINAGRA: Les Hirsch.

LESLIE D. HIRSCH: Good morning. My name is Les Hirsch. I'm the President and CEO of the Cooper Health System in Camden, New Jersey. I'm very thankful for the opportunity to be here this morning and appreciate the Committee taking the time to hear all of our concerns in the industry. I have a statement that I would like to read and will try to-- A lot of the materials have been presented here today, so I'll try not to be too repetitive.

First of all, as you are aware, Cooper Hospital wears a number of hats, first of all as a health-care provider. We're also the largest employer in the city of Camden and among the largest, if not the largest employers in the county, Camden County. As an academic medical center and regional tertiary-level provider, Cooper serves the entire Southern New Jersey region as

a Level I trauma center, Level III neonatal intensive care unit, and the cardiac surgery program distinguished by some of the best clinical outcomes in the state.

Cooper's faculty and medical staff pursue excellence in clinical practice across the broadest array of medical and surgical subspecialties available in southern New Jersey. Cooper also plays a critical role as a community hospital, as it is the primary and specialty-care provider for the city of Camden. Approximately 50 percent of the residents of the city of Camden rely on Cooper for their, so to speak, soup-to-nuts care. Cooper's dedicated faculty physician group has anchored the health-care delivery system in the city of Camden.

And today I will point out that there really has been no mention, when we talk about Charity Care and other issues, on the impact of physicians, because they are receiving not a cent of any Charity Care moneys that are very -- quite a burden. In light of our contribution as an inner-city teaching hospital, Cooper is rightly considered as one of New Jersey's safety net hospitals.

I wish to focus my testimony on three areas, Charity Care, Medicaid, and managed care, which taken together, truly threaten Cooper's ability to fulfill its mission, as well as our colleague institutions across the state. As you are likely aware, and has been mentioned this morning, we are facing the bleakest of times in the hospital industry in this state. Parenthetically, I would say, I've been a hospital executive for over 20 years in the state, and it's the worst that I've seen it in my time. It's already been commented that the operating margins are negative, and we are a full 6 percent behind the rest of

the country. Inner-city teaching hospitals, like Cooper, have been particularly hard hit over the past several years.

We talked about the Balanced Budget Act of 1997, that in this State, if unchecked, about 1.8 billion would be reduced in hospital spending. Even with some of this funding that was restored last year by Congress, we still have a major problem there, and frankly, the worst is still yet to come. We haven't seen the worst of the cuts under the Balanced Budget Act. From the time that New Jersey's hospitals were deregulated until today, statewide operating income has decreased from \$432 million in 1993 to 53 million in 1997. In 1998, 60 percent, as has been mentioned, operated at a deficit.

Operating income at the safety net institutions -- the 17 hospitals that are considered safety net hospitals -- has declined from a combined income of \$142 million in 1992 to a loss of at least 60 million in 1998. This downward spiral in operating margins has been evident for years.

Consider Charity Care, as has been widely discussed today. The Charity Care and hospital relief payments to the 17 eligible safety net hospitals total \$318 million in 1992 compared with 319 million in 1998, even though the amount of documented Charity Care has, again, as has been discussed today, increased dramatically during this period. The most recent calendar year, and as discussed by Dr. Terrill and others, shows that we have between, easily, a \$200 million to \$300 million gap. And I would underscore the fact that this Charity Care is being priced at Medicaid rates, and that's an issue in and of itself. We know that the fund provides \$320 million in reimbursement only.

It's also important that I want to underscore that not only is Charity Care an issue, but also the issue of uncompensated care, which no number has been documented. I would venture to say that that number may equal the Charity Care for now, if not more, that hospitals are bearing. For Cooper, as an example, we on an annualized basis have somewhere in the range of \$25 million in Charity Care charges. If we look at the amount of bad debt for those that are uninsured and that have no insurance and who can't afford to pay, it's in excess of \$30 million.

Statewide documented Charity Care continues to increase to \$20 million to \$25 million a year. The State is paying hospitals on average 66 cents on the dollar for services provided. However, given the current distribution formula, the impact varies widely among hospitals. Cooper, for example, currently is receiving only 51 cents on the dollar of care provided. Lastly, because the Medicaid rates are used to value the Charity Care and hospital special relief cases, the effect of inadequate Medicaid rates has had a compound affect on State payments.

By any measure, the State is failing to adequately fund Charity Care. The problem has become exacerbated over time. Despite Cooper's role as a safety net hospital and an actual rise in the amount of Charity Care, Cooper's Charity Care subsidy has dropped 55 percent from 1993 to 2000, from \$18 million to \$8.1 million in the year 2000. Cooper now receives less than any other inner-city teaching hospital in the state.

In Fiscal Year 2000, Cooper's rate of reimbursement of 51 cents on the dollar is substantially lower than our peers among inner-city teaching

hospitals which average 87 percent -- 87 cents on the dollar of their audited Charity Care charges priced at Medicaid rates.

Charity Care is allocated to hospitals by a formula. The complex formula is structured to reduce the Charity Care subsidy for more profitable hospitals. And God only knows, I empathize with Rich Miller. He's not getting any Charity Care, and he should. The formula also reduces the subsidy in proportion to a hospital's payer mix, the logic being the more that your revenue comes from nongovernmental payers, the more you can shift your Charity Care expenses to these payers. Unfortunately, the formula includes managed Medicaid and managed Medicare business, which are deeply discounted as private pay revenue. In reality, a hospital cannot shift its Charity Care expenses to managed Medicaid and managed Medicare. South Jersey, particularly Camden, Gloucester and Burlington, had a disproportionate share of these types of payers during the period used for the purpose of calculating Charity Care.

With the shifting of Medicaid and Medicare fee-for-service to Medicaid managed care and managed Medicare, the Charity Care formula driving the distribution of the Charity Care subsidies has a net effect of shifting subsidies away from inner-city hospitals like Cooper. The payer mix factor actually worked to reduce Cooper's Charity Care subsidy for FY 2000 from over \$15 million to 8.1 million.

The payer mix factor has had a particularly pernicious effect on the hospitals serving Burlington, Camden, and Gloucester counties, where managed Medicaid and managed Medicare have made strong gains in market share compared with the northern part of the state. For hospitals serving this

region, the Charity Care subsidy dropped from \$15.3 million in 1998 to 10.6 million in 2000. The subsidy, as a percentage of audited Charity Care charges priced at Medicaid, has dropped from 41 cents on the dollar to 26 cents of the dollar of care provided.

Consideration has been mentioned about providing a supplement to Charity Care with additional funding from the tobacco fund. Thirty million dollars is planned to be distributed to those hospitals who do not currently receive Charity Care, thus creating a floor that these hospitals would receive 50 percent.

In light of the critical importance of the role of inner-city teaching hospitals providing care for the Charity Care population, we believe that New Jersey should establish a floor for inner-city teaching hospitals. We propose that the Charity Care subsidies not fall below 80 percent of their audited Charity Care charges priced at Medicaid rates. To institute such a floor, we believe, would reestablish what the Legislature had originally intended to accomplish in creating a safety net for institutions like Cooper, which anchor the health-care delivery system serving New Jersey's inner-city residents.

Let me just move on to Medicaid and talk a bit about that. Our rates are among the lowest in the nation. Cooper is paid approximately 50 percent of its cost to provide care to Medicaid patients. Keep in mind, however, that for Charity Care patients, New Jersey's Charity Care formula actually prices Charity Care charges at Medicaid rates, then reimburses, on an average, only approximately 50 percent of the Medicaid rate.

Medicaid hospital payment rates in 1993 effectively paid hospitals an average of 6 percent above cost. Between 1993 and 1998, the Medicaid

reimbursement methodology was modified no less than four times to yield Medicaid rates that now, on average, are 24 percent below cost. Although the State is spending more on Medicaid overall, the percentage of those payments going directly to acute care hospitals has decreased from 29 percent of total Medicaid payments to 11 percent of total payments. The average payment per Medicaid inpatient case has actually decreased between 1993 and 1997, as compared to other states in our region in which payments have increased.

New Jersey currently uses 1998 as its base year to set Medicaid rates. The State has neither rebased nor updated the DRG grouper in over five years. The current New Jersey DRG grouper is New York State Version 8. Developed in 1991, the New York State Version 8 does not reflect the routine use of recently developed medical technology or current clinical practice.

The effective reduction in Medicaid reimbursement like Charity Care severely impact the inner-city teaching hospitals like Cooper. However, physicians, as I mentioned before, serving inner-city populations are also gravely impacted by inadequate Medicaid rates.

A bad situation has become compounded by Medicaid managed care, as I said. The implementation of mandatory Medicaid managed care has created reductions in revenue in that the payments from HMOs for managed care enrollees are generally less than the Medicaid fee-for-service. Capitation rates were based on 87 percent of Medicaid fee-for-service payments that also included graduate medical education adjustments for rate reductions. Because New Jersey's Medicaid physician fee schedule is one of the lowest in the nation, HMOs have increased their physician payment rates significantly as compared to the Medicaid physician fee schedule in order to attract qualified

physicians, resulting in additional downward pressure on funds available to pay hospitals.

My final point on the Medicaid issue pertains to graduate medical education. All payers prior to deregulation provided graduate medical education payments. In 1992, the total GME received by hospitals was approximately \$600 million, with Medicaid's portion being almost \$70 million of the total. After deregulation, the only payers that specifically pay for GME are Medicare and Medicaid. Currently, Medicaid payments are limited to \$20 million, a decrease of over 50 million. The responsibility for graduate medical education should properly be shared by all. We are mortgaging the future and quality of our health-care delivery system if we do not adequately provide for medical education.

There is clearly a need for New Jersey to substantially improve its Medicaid rates. We would propose that the State raise its rates to achieve parity with neighboring states such as New York. This would provide an important remedy to support the health-care delivery system functioning in New Jersey's inner cities.

The final issue that I wish to address concerns the business practices of managed care. We characterize it as slow pay, no pay, and wrong pay. We believe that they are systematically, inappropriately, or avoiding to pay their contractual obligations. The financial impact of these practices equates to millions of dollars, as has been mentioned before, specifically by John Gantner.

I'll provide you with three examples -- three managed care companies that amount to approximately one-fifth of Cooper's inpatient

business. The first company, which will go unnamed, last year paid its claims on an average of 90 days upon receipt of bills. Some 70 percent of the bills were reimbursed properly. Of the remaining 30 percent, 15 percent of the bills were incorrectly paid, and the remaining 15 percent were not paid at all. This reflected, on balance, a \$2.7 million shortfall on a \$14.4 million book of business.

The second example pertains to a company which over the past year paid its claims on a more timely basis, within 60 days. Unfortunately, 80 percent of the claims were not properly reimbursed. They were paid incorrectly against the contract, what we call shorting. Our people then have to go back and jump through many hoops to reconcile this. The financial impact: 1.7 million.

The third example is a payer paying claims within 60 days, yet 86 percent of the claims were paid improperly, equating to a shortfall in the last eight months alone on a contract of over half a million dollars. Business practices such as these call for more rigorous regulatory review, and something really needs to be done about that.

In closing, let me say just a couple of other points. I want to thank the Committee. I want to thank Senate President DiFrancesco, the entire Committee, Senator Matheussen, the Chair, and all of you for your concern about this issue. I've looked at Senator Matheussen's goals and the Senate President's goals and the Committee's goals of what they're trying to achieve. I think it's very worthwhile and noble. We appreciate it. You've heard here today a lot of issues. It's real.

I will just say in closing for Cooper, we've experienced losses in the last two years of \$16 million per year. We have made the tough decisions and have restructured ourselves, perhaps, more than any institution in this state and are, perhaps, among the most distressed. We've reduced our workforce by 13 percent since 1998, from the executive suite all the way down, up and down the line. We've cut our costs since 1998 by about \$27 million, if you look at our spending that year or spending this year. We've consolidated our closed services, things like global mammography that services the community in centers like the Bergen Lanning Health Center. We've not had a salary increase, a general wage increase for employees for almost two years or over two years, and we're beginning to feel the pressures of the marketplace in that respect.

I point all of that out because despite all of those actions that we've taken, we're still barely breaking even. I'm pleased to say that we've stabilized, and with all the actions that we've taken, we're now at a point where, for the first two months of the year, we're virtually at a breakeven after all of the losses of the restructuring that we've had to go through. At the end of the day, it says that something is really broken in our system, and I imagine that's the reason why we're here today.

Again, thank you, and I will answer any questions that the Committee may have.

SENATOR SINAGRA: John.

SENATOR MATHEUSSEN: I don't have a question, but I just want to say and compliment you -- you still have all your hair for the last two years, Les, and it's nice to see. You've gone-- Of all the hospitals, I know

you've had difficult times, and you took over at a difficult time. You have to make some tough decisions. There are some unhappy people about those decisions. You left this community. You had services here, and to some degree you had to -- you pulled back, and those services are missed, but at the same time, you did what you had to do. We want to try to be there to make things better so a hospital like that doesn't have to just survive, it can flourish.

MR. HIRSCH: Thank you.

SENATOR MATHEUSSEN: So congratulations on what you've done.

MR. HIRSCH: Thank you.

SENATOR MATHEUSSEN: I know it's not been an easy job.

MR. HIRSCH: I hope that my coronary arteries are as good a reflection as my hairline is. (laughter)

SENATOR SINAGRA: Thank you.

MR. HIRSCH: Thank you, Senator.

SENATOR SINAGRA: The last speaker today will be Jeanne Otersen.

JEANNE OTERSEN: Thank you. My name is Jeanne Otersen. I'm the Public Policy Director for the Health Professionals and Allied Employees. We're a union of nurses and health professionals at many of the institutions, including Cooper Hospital, Burlington Memorial University. A number of the speakers today have been the CEOs of our hospitals. I came this morning not to whine about patient caseloads of nurses. That may slip in, but that's not why I came. (laughter)

SENATOR SINAGRA: You can't help yourself.

MS. OTERSEN: Well, I'm the one. I'm warning you, but it's not my intent. The intent was really, I think, to offer something a little bit different. And actually, as the morning went on, I found myself agreeing with Rich Miller, Les Hirsch -- you really get confused here. But I think the concern is that on the one hand the report of Pricewaterhouse, the Department of Health, which I think of all the testimony concerned me the most. The hospitals have two real different kinds of takes, one is that there's too much health care, and the other is that there's too little money. And I just don't think it's as simple as either thing.

I support everything that the hospitals -- all of them said today about needing changes in Medicaid reimbursement and Charity Care and the issue of the uninsured. We're in agreement. There is nothing that nurses and professionals want more than the resources to do their job, in that we want to work together with the hospitals. Where I'm concerned is that I think, as I said, it's not so simple. What we see is that in some cases a real misallocation of money and a real lack of accountability for the money that is given to the systems.

So what we would argue along those lines is that as we give more money to the hospitals, we need to be accountable, we need to monitor, and as I think Senator Vitale said earlier, need to know where that money is going. And I think Charlie Wowkanech really stressed that point, that when we looked closer at some individual hospitals' operating budgets, we really wonder whether they're always an accurate reflection of their fiscal health. We do not deny all the things that have been said this morning about the fiscal crunch, but that what we've seen in looking closer is that a lot of hospitals, not all, have

continued on their building expansions, buying up buildings, investing in real estate companies, buying up physician practices, and creating and continuing to expand for-profit subsidiaries. None of that is in Pricewaterhouse. None of that is public information.

One of the hospitals I looked at has at least four for-profit subsidiaries. Now maybe that's a good thing because of getting some money from those investments. But again, those are tax dollars going into those things that we're not monitoring and we're not regulating. So we have seen hospitals that have laid off nurses, not in this room, that we have seen spend millions of dollars in other areas.

One hospital is spending \$2 million on high-priced consultants that came in to tell them how to reduce nursing staff. They did that, and two years later they had to reverse everything that the consultant came in to recommend because it was a disaster. They used unlicensed personnel, cut back on registered nurses, and it was a disaster, and they reversed what they had done. But that was \$2 million that, my guess is, came out of somebody else's pocket, which is the taxpayers'. That needs to be looked at when we're providing those subsidies. We need to have accountability.

The other issue is the mergers and the acquisitions. One of the things that Pricewaterhouse did say was that they're not producing efficiencies. So are we looking at the money that's expended there, and again, are we monitoring it and controlling it?

On the other side of the coin is what the Department of Health and the report is saying, which is that there's too much health care. And they really rely on three factors: That we have too many beds, too long a length of

stay, and too many staff people. And on the staff issue, I would both agree with Tom Terrill, but also question it. As nurses, what nurses are seeing every day is not the traditional six patients per nurse that they used to have, but nine, ten, and twelve and fourteen in some horrendous cases. They know -- there's the whine -- that there aren't too many staff per bed.

What's not to find in the report is who are those FTEs? Are they actually RNs? I would fall on the floor if you could show me that we have too many RNs per patient when we know what we're seeing in every hospital. And most of the hospital CEOs and, I think, you heard it from both Rich Miller and Les Hirsch a little bit, would acknowledge that they're seeing a staff shortage, not too many staff on the floor. That we're seeing what Senator Vitale also suggested, a nursing shortage, because there have been so many cuts in the system imposed by managed care and funding that the nurses have gone out the door, and they're not coming back very readily because the working conditions have gotten so bad -- whine No. 2.

So I think we need to look at is or do we really have too many staff and who are those FTEs that they're defining that we have too many of? Are they nurses? Are they middle managers? Who are they? That's not in the report. I think we need that information.

Secondly, the issue of length of stay: While in my reading of it we're pretty on par with Mid-Atlantic, it's really the Medicare patient we're talking about. I'm not an expert here, but I would sure like to see more figures that show what the reason for that is before we jump to this conclusion that we should just throw old folks out of the hospital beds faster. That's a solution that's very clearly in the Department of Health. We need to just immediately

reduce our length of stay. No one has shown in those reports what the reason is, what the fallout is, and I think it has been pointed out. Where is our home care to pick that up?

Again, as Les Hirsch commented, we're getting cuts in home care as well. Where do we think these people are going? And while we seem to claim there's too much health care, I don't really buy that. I think that the issue of the uninsured tells us every day there are unmet health needs, not too much health care, and people don't really need it, and that's why we're in a fiscal crunch.

I think also, just to be careful on the issue of overbedded, I've heard both sides this morning. But I can tell you again, from the nurse's point of view, that this spring in North Jersey every hospital we represented, every hospital for a couple of counties, were undivert constantly through the spring. You can say, "flu season," but you know what? We have that every year. We have all kinds of seasonal variations, and if we just close beds, what are we going to do when the crunch comes and the crunch comes. We've closed beds. We've reduced staff. I don't think we can do it anymore. I think we've ratcheted down as low as we can go.

And that, I think, leads us to the last conclusion, which is, well, then just close hospitals. You will have problems in the communities and you should have problems in the communities if we don't do this in a rational way and if we don't second-guess that this is the best thing for communities, that the money will automatically go to other hospitals and boost the bottom line of other hospitals. I don't think that I believe that that's true. I don't think in many cases it's for the best for hospitals to just close.

And I did hear arguments this morning that were very concerning to me, from some hospitals, that it is the best thing and we should make it easier. We should get rid of the certificate of need process and make it easier for them. If you close a plant, you need to provide notice. There is a Federal law. You need to provide retraining. You need to put money in there. You need to guarantee people's health benefits. Why aren't we doing that for hospitals? Why aren't we looking first at the health needs of the community? It's like the Wild West, whatever closes, closes, and we'll try to pick up the pieces. But once hospitals close, it is virtually impossible to reopen them.

And I think that's the real issue of whether we should just allow the marketplace to close hospitals. I think the marketplace is not the solution. I think it's the problem. I think what I'd like to see, in terms of just what our recommendations were and our concerns would be, is that as we look at the money that we do require full financial disclosure. As I have looked more closely at both Pricewaterhouse and some individual hospital reports, the huge sucking sound on hospitals is managed care discounting, and we've avoided that issue. It's not in the Commission's report. The denial payment issue is. The length that it takes them to pay is in there. But the whole fact that these managed care companies are driving down and providing contracts at below cost, we're not even looking at, and that to me is one of the biggest factors.

Yes, you can deal with Charity Care, but if we leave managed care to drive quality, quantity, and everything else about our health-care system, we've all given up our responsibility. And I think the hospitals did that over the last few years, as we all, in this competitive environment, grabbed managed care contracts trying to do, as they said earlier, deal with volume. And this is

where we are today. I really think this Committee has got to look at the managed care contracting issue and jump in there, as individual hospitals are fighting.

We've got too dominated a market at this point with managed care, so I think you need to look at that issue. We certainly disagree with any solutions that this Commission has put out that would cut staff without really examining, that would allow hospital closures without doing a health-needs assessment, involving the community, involving the employees, involving retraining, as you said, alternate uses.

I raise one quick flag on the issue that-- It seems to be the popular thing. You leave the emergency room and then you transfer a couple of other things. I had a friend of mine's mother-in-law die recently in a Philadelphia hospital on her third transfer, went to a hospital that was not just an emergency room, gave her quick treatment, transferred to a second that didn't have a bed for her because they had closed so many beds. So they transferred her to a third hospital. She died in that last transfer. You can never tell whether she would have died anyway, but I think that's going to happen more.

There needs to be a process. Everyone is afraid to step in and let the government do this. If we don't, what hospitals are going to close? It's not going to be the ones that are thriving. That's pretty obvious. It's going to be our small community hospitals, our rural hospitals, our urban hospitals. And we're going to let that happen, and then we're going to be surprised just as we're surprised about a nursing shortage.

So, in closing, I would just ask this Committee to really look very carefully at that Commission report and put out something pretty quickly that

challenges some of their assumptions because I'm afraid that that will be the direction the State goes in and it will be accepted that we have too much health care and that's the problem. And that's not what the nurses see every day.

SENATOR SINAGRA: Thank you, Jeanne.

MS. OTERSEN: Thank you.

SENATOR SINAGRA: Any questions?

SENATOR MATHEUSSEN: I have no questions, no.

SENATOR SINAGRA: Any questions? (no response)

Thank you, Jeanne.

I just want to say one thing before you do your thing. I want to thank staff, my colleagues, for traveling here today, being attentive to what's complicated testimony on a very complicated issue. I personally want to thank our host for having us here today.

And with that, Senator Matheussen.

SENATOR MATHEUSSEN: I wanted to add my compliments as well to our host, but I also want to compliment you, Mr. Chairman, in bringing the Committee around the state, and certainly this is a good example of that. I'm sure we're going to be traveling from South Jersey to northern parts, and we'll be equally attentive to that. But I think it's important that everyone has a chance to participate throughout the entire state in this issue. It's a very serious issue. Obviously, it's very serious from the testimony that we heard today, and we have to take serious action to it.

I also want to just mention our host, Kennedy Hospital, has offered anyone would like so -- maybe you were on the run -- but there are

some luncheon-- Next door, you can grab something and get something to eat in there.

So, thank you for coming, and thank Kennedy Hospital.

(MEETING CONCLUDED)