The Fund Reporter

Published by The Consumer Commission on the Accreditation of Health Services

Volume 3, No. 1 January 1990

NOW IS THE TIME TO AMEND UNFAIR NEW JERSEY DRG LAW

When the State of New Jersey enacted its DRG hospital charge system several years ago, it also created the *'Uncompensated Trust Fund.'* The State recently changed the law (P.L. 1989) to permit unpaid hospital bills to be considered debts to the *Uncompensated Trust Fund*, and to permit attaching income tax refunds or homestead rebates of persons whose bills are unpaid.

A union-management fund (an ERISA fund) frequently does not pay a hospital bill until it resolves such matters as eligibility, medical necessity or the accuracy of billing. *There is no provision for appeals or hearings prior to seizure!* This authority to seize assets without an appeal process, even when the patient is an innocent bystander in a legitimate dispute between the union health fund and a hospital, is an onerous and abusive practice.

The New Jersey legislature should amend or, even better, eliminate this portion of P.L. 1989 immediately.

At a meeting of hospitals' financial personnel held recently in Princeton, a speaker representing the *Health Department Uncompensated Care Trust Fund* stated that as early as December, 1989 hospitals shall be required to send information to the state's Health Department and the Department of Treasury on patients who have outstanding balances. The State will compare this with their own tax records, based on Social Security numbers, and will identify those persons who have tax rebates and/or homestead rebates due.

A postcard will then be sent to the patient and the hospital indicating that a deduction shall be made from any tax refund and/or homestead rebate to pay this outstanding debt. The only remedy for an individual would be to contact the hospital to make arrangements to pay the alleged debt, or to indicate that someone had mixed his or her Social Security number with someone else's. Only the hospital can then notify the State not to make any deductions.

By all accounts, the hospital industry is opposed to this process because of the problems it will cause state

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EARLY WARNING SIGNAL!

Major Attack is Anticipated On Tax-Exempt Status of Funds

All signs point to a major attack next year on the tax-exempt status enjoyed by employee benefits plans as members of Congress seek ways to increase tax revenue.

At a conference of benefit fund professionals held in November in Washington, D.C., Phyllis Borzi, counsel to the House Education and Labor Subcommittee on Labor Management Relations, warned "protecting employee benefits from taxation will be a tough fight" and will require coordinated resistance by labor and management. She predicted, however, that deep divisions between the business community and organized labor will make that a difficult task for both sides.

Borzi warned "No one will be safe next year. . . we're going to be fighting for our lives. . ." She said taxation of employee benefits is a much bigger threat in 1990 than it was in 1986, when Congress enacted the most recent major tax reform. "The challenge to all of us is to figure out a way to assure that the threat doesn't become a reality."

She emphasized that "deficit-driven legislation" will continue to be a problem in the years to come. If Congress passes a bill to reduce the deficit, it will be a relatively minor skirmish compared to the all-out war next year to meet the targets of the Gramm-Rudman-Hollings deficit law, she said. □

STATE'S DRG CASE PAYMENT SYSTEM SHIFTS COSTS TO PRIVATE SECTOR

By Donald Rubin

In 1988, New York instituted a hospital reimbursement system that was heralded as the most efficient and cost-effective in the nation. The DRG Case Payment System legislation was intended to promote the welfare of the citizens of New York State and to control health care costs by controlling hospital charges.

The results of that system are now coming in and it looks like a windfall for New York State's Medicaid program and for the hospitals, a fiasco for cost containment and trouble for ERISA funds. The DRG system has not saved money for the self-insured ERISA funds, but instead has resulted in a substantial increase in hospital costs for these funds.

The DRG theory of controlling hospital costs sounds good, but as often happens, the practice works out differently. This legislation is not cost-saving but rather *cost-shifting*. The State has effectively shifted a large part of the cost of its Medicaid program to the private sector.

Blue Cross, commercial insurers and the self-insured welfare funds are paying the tab for a cost-shifting hoax perpetrated on the citizens of New York State. Hospital costs in 1988 and 1989 have gone up approximately 25% a year since 1987. The DRG amounts were set much higher than they should have been. The only beneficiary of this cost-shifting has been the State, which benefits from a *case payment* method over a *per-diem* methodology because Medicaid patients stay in the hospitals much longer than their insured neighbors.

Besides cost-shifting the system itself generates abuse. One such loophole is vividly described as *"DRG creep."* When a patient is admitted to a hospital, his or her illness or injury is assigned a DRG. All that a hospital has to do to provide a higher revenue is to find a way for the diagnosis to "creep" into a more expensive DRG category. Some hospitals have encouraged doctors to code the patient's condition in a DRG category that generates a higher economic return for the hospital. Many people are hospitalized for more than one reason. A different DRG code on the claim form submitted to the insurance carrier or the self-insured fund allows a higher charge for the admission.

Another method hospitals have used to maximize their income is to pressure doctors to discharge patients at the earliest possible moment. The DRG system was intended to discourage prolonging hospital stays beyond medical necessity. Now hospitals are tempted to cut stays dangerously short in order to keep more of the DRG allowance and to admit as many patients as possible. Many patients now feel pushed out of hospitals prematurely, before adequate home care or other alternatives to hospitalization can be arranged.

If the patient has not fully recovered, early discharge can lead to prompt readmission. This situation, called *"churning"* admissions, means hospitals can bill twice for treating one illness or injury.

Self-insured funds and insurance carriers find it nearly impossible to verify whether they are being charged the proper amount under the DRG system. No individual fund or insurance carrier can audit the complete medical record for every patient hospitalized in New York to determine if the bill is coded properly and the DRG price correctly calculated.

Some funds have initiated DRG validation programs. These DRG audits are very expensive and add considerably to the cost of providing hospital coverage. In most cases, the funds use outside DRG and utilization review programs. Some use outside consultants and fund staff. Hospitals tend to accept review results more readily when reviews are performed by independent professionals.

The DRG system has been an economic bonanza for some hospitals, while patients have suffered through premature discharge and ERISA funds from excessively high bills. *The New York Times* was exactly right in its April 2, 1984 editorial: *"If hospitals have a new incentive, it's to manipulate the system to keep the money flowing, not to reduce costs."* □

The Fund Reporter is a publication of the Consumer Commission on the Accreditation of Health Services.

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THE FUND REPORTER RESUMES PUBLICATION

The Times Call For It!

We are very pleased to announce, with this issue, resumed publication of *The Fund Reporter* as a publication dedicated to helping welfare and pension funds in their day-to-day tasks by providing timely and useful information in all areas of common concern and interest.

If our publication makes even a small contribution toward guiding those who share the responsibility for providing and administrating employee benefits it will serve a valuable function.

And the times call for it! These are challenging and uncertain times for everyone in the welfare and pension field: many funds are in dire financial straits, some of them facing bankruptcy as health costs rise at a rate of 20 to 25 percent yearly. The inflation in hospital and medical charges far out-distance the rise in all other items in the cost of living and nowhere is there any sign of effective governmental intervention to regulate the private business of medicine.

With costs rising relentlessly, funds are faced with the dilemma: (1) **How can health care costs be contained?** and (2) **How can unions and employers negotiate adequate contributions to cover the inflation of health care costs?**

In addition, funds are confronted with federal and state efforts to tax pension and welfare contributions which have never been taxed in the past and this fight will come to a head in the new year, as the Congress strikes out in all directions to solve its fiscal mess. (See 'Early Warning Signal' in this issue.)

In addition to timely articles providing information on government actions that could affect the cost of benefits and the functioning of funds, the *Fund Reporter* will carry articles on health care which are written for possible reproduction in trade union and other publications.

As always, we welcome articles and suggestions for articles in keeping with the *Fund Reporter's* area of special interest. □

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MEET THE NEW EDITOR OF The Fund Reporter

Charlie Klare, who retired recently after a 40-year career in the trade union movement, the last 35 of these years in the Teamsters Union, will serve as Editor of *The Fund Reporter*, commencing with this issue. At the time of his retirement, Klare had completed 12 years as the principal officer of the Teamster Union's Brewery and Soft Drink Division, covering the U.S.A. and Canada. Prior to that he served for many years as the Division's Director of Organization.

Klare's background includes experience as an editor of various trade union publications. He has also served as Administrator, Trustee and Fund Chairman of several employee benefit funds in the beverage industry.

He invites suggestions for articles and proposed features relevant to the publication's special area of interest and can be reached by calling the *Fund Reporter* office.

NOW IS THE TIME TO AMEND N.J. LAW

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residents. There is also growing concern that confusion in Social Security numbers, problems with legitimate disputes, failure to receive the postcard, etc., will cause unnecessary harm. In addition, there is the total absence of any due process provision and it is up to each hospital to approve the need to make deductions from tax refunds and/or homestead rebates.

Needless to say, the problem will impact most harshly on lower paid workers and the working poor.

The State representative acknowledged that most of the people involved do not have income tax refunds or homestead rebates and that the cost will probably not be justified by the possible additional income. The State representative also reported that corrective technical legislation will be proposed in the coming weeks to correct and clarify requirements of the hospitals in their collection efforts. The State is working with the hospital industry to prepare this corrective legislation but there is no mention of participation by other interested parties in this important matter.

We believe this is an ideal time to amend the legislation to delete the onerous provisions regarding deductions from tax refunds and homestead rebates. □

CHOLESTEROL CONFUSION IS RAMPANT

The American people are on a 'Good Health' kick and high up on the lists of do's and don'ts to achieve better health, and perhaps even greater longevity, is the scare word CHOLESTEROL. **Confusion reigns!** In the past several years we have witnessed a barrage of conflicting and confusing words of advice about the impact of high cholesterol on the cardiovascular system, and the magic numbers relating to acceptable cholesterol levels have bounced up and down like a yo-yo.

What to do?, who's right? Since this is a serious matter concerning each individual's personal health there is only one sound advice: consult your personal physician and follow your doctor's program for *you*. **Stop driving yourself crazy!**

Here are two current opinions on the subject which demonstrate how widely apart knowledgeable professionals are on this subject.

Benefits of Lower Cholesterol Reaffirmed by Heart Groups

(from N.Y. Times, Nov. 16, 1969)

The American Heart Association and the National Heart, Lung and Blood Institute have issued a joint statement seeking to quiet doubts about the need for most people to lower their cholesterol.

The association and the institute said that the evidence that reducing cholesterol saves lives is overwhelming. "The evidence more than justifies the current national campaign for cholesterol control," they said.

The statement was intended to counter an article in the September issue of the *Atlantic Monthly* which argued that there is no firm proof that lowering blood cholesterol levels saves lives or that people live longer by changing what they eat.

The latest statement in support of lowering cholesterol was issued at an annual scientific meeting of the American Heart Association at which heart experts outlined the case against cholesterol. They all endorsed the generally accepted standard that a person's blood cholesterol level should not exceed 200.

Dr. John C. LaRosa of George Washington University said "If you give the message that cholesterol is a myth, it is wrong. It is important that we detect and treat it."

Researchers say cholesterol kills by plugging up the blood vessels that feed the heart muscle.

Another panel member, Dr. William Castelli, the director of a long-term Federal heart study in Framingham, Mass., said "There is overwhelming data that in addition to lessening your heart attack risks in your 40's, 50's and 60's, you will live a little longer by following a better diet."

"All three studies show that whether you use diet or drugs, you can lower cholesterol dramatically," said Dr. Basil M. Rifkind of the National Heart, Lung and Blood Institute.

Public is Misled About Cholesterol Says Author

(from Health Facts, Oct. 1989)

Heart Failure by Thomas J. Moore (Random House) is a "must read" for anyone who has been told his or her cholesterol level is too high. First, heart disease researchers discovered the strong association between high blood levels of cholesterol and an increased incidence of cardiovascular deaths. The next order of business was a scientific demonstration of a good preventive strategy. Since the early 1970's several well-designed, large-scale government-sponsored studies set out to prove that lowering cholesterol with diet and/or drugs can reduce the incidence of heart disease.

The findings were disappointing. Even the most rigorous low-cholesterol diet produced only minimal reductions (less than 7 percent) in blood cholesterol levels. Cholesterol-lowering drugs, complete with very unpleasant side effects, decreased the number of cardiovascular deaths but not the overall death rate.

Mr. Moore has applied his considerable investigative reporter skills to a critical evaluation of the various studies that attempted to show a benefit to cholesterol reduction. Each study either failed completely or produced benefits that were marginal at best. But the mounting evidence did not dissuade the anti-cholesterol enthusiasts. The idea that the cardiovascular death rate could be reduced by lowering cholesterol levels had already become firmly entrenched in the medical research community's belief system.

Over a ten-year period, National Heart, Lung and Blood Institute had spent 60 percent of its $495 million budget for clinical trials that were both "bold and reasonable." Instead of admitting failure, writes Mr. Moore, "The heart institute researchers went shopping for a statistical test their results might pass."

NYS STATUTE REVISIONS IN '90 MUST CONTINUE HOSPITAL DISCOUNTING

The DRG system is in place through December 1990. The New York State Legislature will consider a revision of the statute in the early part of 1990.

ERISA welfare funds must be on the alert that the State will not prevent them from continuing discount arrangements with the hospital. Every few years when hospital legislation has to be rewritten, Blue Cross lobbyists attempt to the get the State to limit discounts to only Blue Cross and other Article 43 corporations. The insurance companies want to do away with the discounts entirely which would mean that Blue Cross and the self-insured would be required to pay considerably more money for hospital care.

These issues will be joined in a major legislative donny-brook next year. The outcome of this fight will affect the solvency of almost every welfare fund in New York. The legal climate now favors Blue Cross over self-insurance more strongly than ever. This is a clear restraint of trade in Blue Cross' favor.

First, let's look at hospital discounts. Negotiations are the cornerstone of cost control in a free market economy. Government regulations or restrictions on the right to purchase hospital care can only have an inflationary effect.

- The only self-insured groups that have negotiated discount rate agreements with hospitals are ERISA funds.
- Self-insured ERISA funds provide hospital coverage for about half a million people, union members and their families.
- The amount of money available to these funds to pay for hospital coverage is limited to what employers are willing and able to pay when contracts are negotiated.
- These funds chose self-insurance for administrative efficiency and economy, and for better control of quality and cost, than was available from Blue Cross or any commercial carrier.
- Self-insured ERISA funds have led the way in health care cost and quality control.
  - One of these funds developed the first mandatory second opinion program in the country.
  - These funds developed the first meaningful program of utilization review.
- Many of these funds could not afford to provide full hospital coverage without discount hospital rates.
- Many of the people covered by these funds are the "working poor" from low-wage industries. If they did not have this coverage, they would be unable to pay hospital bills or buy other coverage.
- Many of the employers of these workers could not stay in business if their costs increased significantly.

If negotiations were disallowed, it would have a catastrophic effect on the self-insured ERISA funds. Hospital costs for these funds would immediately increase by 10 to 13 percent, with no increase in income available.

- If these funds remained self-insured they would have to choose between:
  - continuing full hospital coverage, but dropping most other benefits, or
  - limiting hospital coverage to a few hundred dollars per day, leaving members to pay most of their own hospital bills.
- If these funds dropped self-insurance:
  - they would have to buy hospital coverage from Blue Cross, and
  - other benefits would have to be cut, since Blue Cross costs significantly more than self-insurance.

There would also be effects on hospitals that were not considered by the legislature:

- If the self-insured funds cut hospital benefits:
  - the total number of admissions would drop, since the uninsured do not seek treatment as often as the insured; and
- Bad debt, Medicaid and charity care costs would rise, since many of the people formerly covered by these funds could not afford to pay for hospitalization when it becomes unavoidable.
- If these funds maintained full hospital coverage through Blue Cross it would cost them much more.

From the outset, the self-insured ERISA funds have protested the application of this legislation to their activities. We believe that the legislature should take off all restrictions on negotiations now and in the future.

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HOSPITAL DISCOUNTING

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It is our feeling that opening up rate negotiations to other self-insured groups would definitely lead to a broadening of full hospital service contracts. There are a number of self-insured groups that are reimbursing hospitals on an indemnity basis. These policies usually cover room and board in full and $1,000 or $2,000 miscellaneous. They usually have an 80% major medical override after $100 or $200 deductible.

These groups are picking up 88 to 90% of the members' hospital claims. Opening up rate negotiations to this group would mean that for the same or slightly additional costs, they could offer a full service contract.

It is a myth that hospitals are forced to negotiate inappropriately low rates. No combination of self-insured groups have enough claim volume to force any hospital to negotiate. Hospitals are run by very capable and fiscally responsive people. □

SAMPLE OF COLLECTION FORMS USED BY NEW JERSEY HOSPITALS

THIS URGENT NOTIFICATION IS YOUR LAST OPPORTUNITY TO RESOLVE YOUR ACCOUNT

Did you know that the hospital is mandated by New Jersey law to use all of the following remedies to settle patient accounts?

- Collection Agency
- Legal Action
- Homestead Rebate Attachment
- TAX REFUND ATTACHMENT

Within (10) days your account will be transferred for these recovery actions. You may deal with a collection agency, an attorney, or the NJ State Treasurer after 11/30/89.

IN OUR NEXT ISSUE . . .

A full report, analysis and commentary on the 'UNICARE', the proposal by the New York State Health Department to restructure health benefit plans and health care systems in New York and place them under state control.

Published by Consumer Commission on the Accreditation of Health Services, Inc.
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