The Fund Reporter

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NEW JERSEY'S DRG HOSPITAL PLAN FACES CHALLENGE IN U.S. COURT

New Jersey's DRG program for computing hospital payments, widely regarded as a dismal failure, now faces a challenge brought in the New Jersey Federal District Court charging the program is in conflict with federal ERISA regulations. The suit has been filed by the United Wire, Metal & Machine Health and Welfare Fund and Jack Stoll, a covered Plan participant.

The action seeks a federal declaratory judgement and injunctive relief declaring that the DRG regulations promulgated under the New Jersey law are *"preempted"* as to the Fund and member Stoll by the federal Employee Retirement Income Security Act of 1974 (ERISA).

Dennis M. Silverman, the Administrator of the Fund stated that the reason for bringing the lawsuit is that *"New Jersey costs have risen greater than any other area, and the way New Jersey calculates charges violates ERISA and hurts the Fund's ability to provide benefits for our members."*

REAL COSTS vs DRG CHARGES

The Fund charges that the Jersey statutes require the Plan to pay DRG amounts for participants utilizing health care facilities, under DRG regulations, which are unrelated to the actual costs or charges of the participants care. As a result, Silverman argues, the DRG regulations *"place the Plan fiduciaries at risk with its members"* and are *"incompatible with ERISA and LMRA."*

The Fund also points out in its suit that *"the Fund by its terms can only pay that which the individual is responsible for. Thus, the State law attempts to require the Fund to pay more than the Fund's plan actually allows."*

The suit cites the case of a covered participant to demonstrate how the DRG regulations act to strangle ERISA funds and all self-insured and direct payment funds in the State. The individual was hospitalized at the Morristown Memorial Hospital for 15 days, from February 27 to March 14, 1989.

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EXCERPTS FROM FUND'S COMPLAINT

Following are the key points contained in the complaint filed in the U.S. Federal Court by the United Wire, Metal & Machinery Health and Welfare Fund charging that the New Jersey DRG regulations are in conflict with ERISA and other federal regulations covering the Taft-Hartley funds:

- The Fund seeks by its action to obtain a federal declaratory judgement and ancillary injunctive releif on the grounds that the Jersey regulations are preempted for the Taft-Hartley funds by cited federal ERISA and other regulations.
- The New Jersey statute and regulations require the Plan to pay health benefits in accordance with a Diagnostic Related Group (DRG) system assignment which charges the Plan and Participant with contributions and costs unrelated to actual costs of participant's care.
- These unrelated costs include pro-rata contributions for uncompensated care, care of the medically indigent, research, education and other factors unrelated to participant's care.
- The system denies the Fund payment differentials allowed to other 'Payors' with open enrollment and deny to the Plan and Participant the right to pay the same hospital fees as a person who possesses no hospitalization benefit coverage.

DRG Court Challenge

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Actual charges for this patient for all services provided totaled $12,374.91; however, for DRG billing purposes he was placed in the category of 'Coronary bypass with cardiac catherization' requiring payment of $32,235.10.

Stoll, at the low end of hospital confinement and treatment, was grouped with patients who underwent quadruple bypass and other much more complicated cardiac surgery and many more days of hospital confinement.

The Fund's complaint charges that almost 60% of the actual cost of the participant's confinement is tacked on to the bill to subsidize uncompensated care for charity cases, indigent cases and bad debts from other patients who do not pay their bills. The 'tack-on' also goes towards covering the gap between what Blue Cross, Medicaid and Medicare reimburse hospitals under the DRG system and what they should be paying to cover costs.

Silverman said that of the $32,000 billed by DRG guidelines, almost $8,000 represented payment for indigent patients not covered by the Fund.

In a recent newspaper account, the New Jersey Carpenters Funds, which pays hospital bills for some 10,000 carpenters, reported it had reviewed 134 hospital bills from April and May of this year and in all but 10 cases it found that the DRG billing exceeded the hospital's itemized charges. One carpenter, for example, had a pacemaker implanted during a three-day hospital stay. His DRG bill came to $16,355 while the itemized charges were only $5,756.

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One fund has reported to us that it recently reviewed all claims paid-out over a 15-month period to almost all acute care hospital in New Jersey. The result of the review showed DRG charges amounting to $19.2 million while actual charges amounted to $12.1 million—a payment of almost 159% of true charges!

HIGH HOPES FIZZLE

The action brought by the United Wire Fund and many others is only one facet of the universal dissatisfaction with the Jersey DRG program expressed by funds, patients, providers, insurance companies and the State's citizens.

When the program was initiated, over a decade ago, it was hailed as a *"pace-setter for the nation"* and held out hope that it would finally curb runaway hospital costs. It has failed miserably!

Instead of controlling hospital costs it has brought about enormous increases in hospital and health costs and created chaos in the health care industry. It was certainly become a cost-containment fiasco as far as the self-insured ERISA funds as concerned.

Governor Florio's Commission on Health Care Costs reported recently that instead of containment, costs rose 60 percent over the past five years. It estimates that the cost of providing care for New Jersey's one million uninsured poor will exceed $600 million this year, up from $350 million in 1987—an increase of 171%!

FLORIO PLEDGES CHANGE

Gov. Florio has acknowledged that the DRG systems is not working and is committed to making fundamental changes. He said, *"We need a system where everyone knows what's going on...It's an unaccountable system that is rapidly driving up costs."* The Governor has appointed a Commission on Health Care Costs which is expected to issue a report in October.

Florio told the Commission in May that together the uncompensated-care surcharge and the Medicare and Medicaid cost shifts amounted to a tax, *"A burden on the people and businesses who pay for their own insurance"*. He called the situation a *"disincentive to purchasing health care insurance"*, causing a *"deadly spiral...higher health care costs mean higher insurance premiums which results in fewer people insured..."*

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A SYSTEM IN SHAMBLES

The New Jersey Hospital reimbursement system was created as a *"comprehensive, unique and innovative approach to the control of hospital costs."* It has, instead, created a shambles of New Jersey's health care reimbursement procedures and costs.

- It was implemented to shorten the average length of admission, but has had the opposite effect;
- It was implemented to decrease the cost of the average admission but, instead, the average cost of admission has skyrocketed beyond the average hospital care costs within the region and the nation as a whole, so that New Jersey health care costs have increased more than 60 percent in five years. In fact, it costs the funds more because the hospitals get paid extra if the stay is lengthy.
- The cost of providing hospital care for the one million New Jerseyans, mostly the working poor, who cannot afford health insurance will in 1990 exceed $600,000,000; up from $350,000,000 in 1987
- Insurers and patients pay a surcharge of up to 23.3 percent on every hospital bill to fund the Uncopensated Care Trust Fund. The surcharge for charity care and bad debts adds over $1,000 to the average hospital bill in New Jersey.
- The DRG system, which has become a *"cost-plus"* revenue enhancement mechanism rather than a cost inhibitor, has been responsible for staggering charges, mounting hospital deficits, and wildly fluctuating rates that do not reflect actual costs.
- The Governor of the State of New Jersey has described the DRG system as *"very complicated"* and as *"..an unaccountable system that is rapidly driving up costs."*
- It encourages the manipulation by hospitals and physicians of coded diagnoses, known as *"creep"*, and a hospital has an incentive to assign to each patient an illness which will result in the greatest hospital revenue, thus rewarding hospitals for deciding ambiguous DRG assignments; and encouraging hospital staffs to maximize reimbursement as well as the minimum expense.

—From the Complaint filed by United Wire, Metal & Machine Health and Welfare Fund

ERISA FUNDS MUST WIN THE RIGHT TO NEGOTIATE DISCOUNT RATES

Revision or total elimination of the DRG program does not solve the crucial problems of self-insured Taft-Hartley funds. In order to carry out their mandate and to act in the interests of their covered participants, the funds MUST win the right—now being aggressively undermined by the NJ State Department of Health—to bargain directly with hospitals for discount rates.

ERISA funds are treated as in the same category as commercial insurance carriers and are denied the right to enjoy discounts such as those provided for Blue Cross, HMO's, Medicare and Medicaid.

In its Complaint filed in the U.S. District Court the Local 810 fund charges that pursuant to Jersey regulations *"...a differential from the DRG rate, amounting to a discount, is offered to certain groups of payors...while plaintiffs suffer the discrimination of being required to make up for the discounts offered to others in higher fees to them. Thus, because the Plan is only open to members of a particular employee class (i.e., members of the bargaining unit); and notwithstanding that there may be no bad debts arising from Fund coverage...participant and the Plan were billed $1,029.78 over and above the DRG rate..."* in the cited case.

In this connection, the Complaint adds, *"the Fund (and others similarly situated) is categorized with commercial profit-making insurance carriers, as not being entitled to a discount for providing a socially useful purpose, setting it apart from Blue Cross, Medicaid, HMO's and Medicare..."*

DRG Court Challenge

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NJHA SUBMITS RECOMMENDATIONS

The New Jersey Hospital Association, following a six-month study by a task force of hospital officers, has submitted a report containing 28 recommendations to the Florio Commission on Health Care Costs. The proposals call for a substantial overhaul in the DRG payment system.

The NJHA proposals are broad in scope but focus on recommendations for overhaul of the hospital payment system. Although shying away from suggesting the complete scratching of the DRG payment system, the proposals call for what amounts to a complete overhaul of the system.

The hospital executives' recommendations, along with those of many other groups, will go before the Governor's Commission for study and consideration with a target for submission to Governor Florio toward the end of the year.

STAKE OF THE TAFT-HARTLEY FUNDS

The Taft-Hartley funds have a big stake in the program finally recommended to the Legislature by Gov. Florio, going beyond the immediate problem of curbing spiraling hospital costs. It is imperative that there be an end to the discriminatory practice of barring self-insured funds from negotiating with New Jersey hospitals for discount rates. The New Jersey Health Department must cease its pressure on the hospitals not to negotiate such discount rates with ERISA funds. It now becomes more than ever necessary that Union leadership and fund administrators command some input in the proposals finally brought before the Governor.

JAY RUBIN: OUTSTANDING LABOR LEADER PIONEERED EARLY HEALTH-CARE PROGRAMS

My father, Jay Rubin, died last month.

He was an inspiration to me and to countless others. While he was a very private person, he was able, with great dignity and charisma, to organize New York's hotel workers into one of this city's largest organized forces. When he retired in 1978, there were 30,000 union members affiliated with ten local unions from different internationals in the New York Hotel Trades Council.

He was proud of the fact that when he retired, the hotel industry was 100% union in New York City. He was also responsible for building local unions for hotel workers in Puerto Rico and the Virgin Islands.

Twelve years after his retirement, he still couldn't go into a hotel or major restaurant without being greeted by old time union members who would thank him for making their life and working conditions better. He was both amazed and proud that after so many years, working people still remembered and were grateful.

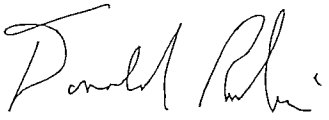
With integrity and honesty, he was one of the many leaders who built the trade union movement in America.

He was also proud that he built one of the largest pre-paid medical plans in the country. At one time it was the third largest program in the country after Kaiser and HIP, covering 100,000 people. He also served as the chairman of the New York City Central Labor Council Hospital and Medical Care Committee and served on the New York City and State Health Planning Councils. He was the labor representative on the Blue Cross Board of Directors for over ten years.

When I went into business twenty years ago, he didn't believe that it would be possible to compete with Blue Cross. As a Blue Cross board member, it took him many years to recognize that self-insurance was a viable option.

Over the years he never offered to help in opening any doors, nor did I ever ask his help in that. He believed that the only way to be successful is to confront the challenge. That was part of his legacy.

There will be a memorial service this coming fall or winter.



Donald Rubin is President of MULTI PLAN Inc./DR Inc.—a PPO Network.

PATIENTS' RIGHTS SPELLED-OUT IN DISCHARGE REVIEW PROGRAM

By Joseph B. Stamm, M.P.A. Executive Director
NEW YORK CITY HEALTH SERVICES REVIEW ORGANIZATION

A new era in hospital reimbursement was ushered in January 1, 1988 when a new, all-payor Prospective Payment System (DRGs - Diagnostic-Related Groups) was implemented. In acute hospital care settings, customary per diem reimbursement rates were replaced by an all-inclusive fee for specific diagnostic groups regardless of the length of stay. Exceptions were made if the length of stay or the overall cost of a specific hospital stay exceeded a specific threshhold.

The new reimbursement system was intended to control hospital expenditures, rewarding efficiency in operational management. Concerns were raised, however, that such a system would ultimately lead to premature discharges, which could result in higher readmission rates or even worse, might cause serious harm or even death to the patient ("sicker and quicker discharge").

In response to this concern, the State Hospital Review and Planning Council amended the statutory requirements and established a Discharge Review Program which would assure appropriate discharge of hospital patients under this new reimbursement system. As stated in the State of New York Department of Health Memorandum (Series 87-96) *"no patient who requires continuing health care services may be discharged until such services are secured or determined by the hospital to be reasonably available to the patient."*

The new Discharge Review Program provides the patient with the right to receive the following:

1. An appropriate written discharge plan.
2. Written notice at admission spelling out the patient's rights while in the hospital as well as the Discharge Review Process.
3. A notice at discharge informing the patient of his/her appeal rights.
4. A review of their discharge by an Independent Professional Review Agent (IPRA) approved by the New York State Department of Health. Not covered under this process are Title XVIII patients (Medicare) who are covered under a separate federal appeals process.

In order for hospitals to comply with the new statutory requirements, each institution in New York State was required to enter into formal agreements with one or more IPRAs. Notable exceptions to this rule were the following patients:

A. Those whose payments are covered by the State Agency. In this instance, the State Department of Health designates its review organization and
B. Article 63 (Blue Cross) and Article 44 (HMO corporation enrollees). These corporate entities had the right to seek IPRA designations themselves or select, as their representative, from the State's approved list of agencies.

APPEALS PROCESS

IPRA appeals may be requested when (1) the hospital and the attending physician disagree as to the appropriateness of the patient's discharge date, or (2) despite the fact that the attending physician and the hospital agree as to the appropriateness of the discharge, the patient and/or his/her representative disagree. The patient, however, must appeal by noon of the day after receiving the discharge notice to avoid any financial liability during the appeals process.

The review agency, upon receiving an appeal, may request a copy of the medical record before it issues a decision. It must also discuss the circumstances of the specific case with the hospital, attending physician, and the patient and/or his/her designated representative. Decisions must be rendered within 24 hours of receipt of the medical record.

Decisions rendered in favor of the patient automatically authorize continued stay at the hospital and thus it is deemed necessary and appropriate for payment purposes. Subsequent discharge attempts by the hospital may be appealed again until the IPRA agrees

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PATIENT'S RIGHTS SPELLED OUT

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with the hospital that the patient is discharge-ready and the discharge plan is both reasonable and available.

RESULTS

Initial evaluation of the program highlights the following:

- Less than 50% of the hospitals are implementing the program correctly. Patients often are not aware of the program and are not receiving the necessary information regarding their appeal rights.
- Less than 1% of all patients discharged have requested an appeal. This may be associated with the fact that the program is relatively unknown.
- Approximately 35% of the appeal decisions are in favor of the patient.

Despite the fact that the program is not well understood and not fully implemented, it is an important vehicle for patients and their families. It allows them the right to challenge decisions rendered by individual providers and/or institutions and gives them an opportunity to obtain an objective assessment as to the appropriateness of discharge.

In Our next Issue...

THE MEDICARE MESS!

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