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Court Approves Temporary Injunction In Fund's Hospital-Billing Suit

U.S. District Court Judge, Alfred M. Wolin, has approved a Preliminary Injunction on behalf of United Wire, Metal & Machine Health and Welfare Fund enjoining St. Joseph's Hospital and Medical Center *"from commencing or prosecuting lawsuits against United, Javier Restrepo, and all other United Participants who have received or who will receive medical care at St. Joseph's."*

The order restrains the Hospital from any collection efforts of any kind for *"fees or costs over the lesser of the patient's actual costs or DRG amount due"*. In addition, the Judge ruled that St. Joseph's shall *"dismiss without prejudice and without cost, all lawsuits pending against United or any United Participant who has received medical care at St. Joseph's Hospital"*. He made clear, however, that such dismissal shall not waive the Hospital's right to reinstate such proceedings upon final disposition of the pending court action.

The United Fund had initiated its request for an injunction pending court action on its challenge to the entire New Jersey system of billing for medical care for patients who are participants in United and similar self-insured Taft-Hartley funds. The Fund has cited the conflict between New Jersey law and Federal ERISA provisions under which the Fund's Trustees operate, as well as other defects in the New Jersey regulations.

Billing For Excess Costs

The Fund's injunction petition charged, as did its briefs in the court action, that the Hospital and other New Jersey hospitals *"are billing in excess of actual costs, pursuant to New Jersey statutes and regulations"* which are preempted by the ERISA Act of 1974. This practice, the Fund charged, *"also violates the United States and New Jersey constitutions as illegal special legislation and an improper delegation of taxing power by the legislature"*.

Dennis M. Silverman, the Fund's Administrator, agreed that pending the outcome of the litigation United *"agrees to pay all 'actual' costs incurred by its Participants at St. Joseph's Hospital"*. He adds, *"The Preliminary injunction was sought only to the extent that any effort is brought by St. Joseph's to collect any portion of a medical bill which exceeds actual costs incurred by the patient in the course of the patient's treament."*

DRG Charges vs Actual Costs

The hospital bill of covered Fund participant, Javier Restrepo, a co-Plaintiff in the injunction proceeding, is cited by United Fund as an example of how New Jersey hospital billing regulations conflict with specific provisions of the 1974 ERISA Act. Restrepo, and the United Fund were billed the amount of $2,834 for services provided by St. Joseph's Hospital in accordance with its DRG fee schedules. His bill, however, showed that *actual costs* for the medical care he received came to $731.00. The Fund, therefore was charged the amount of $2,103 to cover medical costs of people not covered by the Fund.

The DRG billing rate, says Administrator Silverman, is not just a calculation of the average cost of treatment for a given condition. *"Rather, the DRG rate utilizes the average treatment cost as a base and then adds to that fee to subsidize costs incurred by patients who cannot meet their bills for one reason or another."* Among these are charity cases, indigents, bad debt patients who fail to pay their bills as well as a differential

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FEDERAL COST SHIFTING DRAINS FUNDS . . . P. 3

Judge OK's Fund's Injunction Bid

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to makeup the difference between that which Medicare reimburses for elderly patients and the amount of the DRG bills incurred by them. Also such additional items as: medical education programs, out-patient programs and other programs which may be socially of great benefit but should not be financed by charges to the non-profit, limited benefit ERISA fund.

Unequal Fee Charging

In addition to the non-patient related costs billed to the Participants, the DRG system also indirectly bills the Fund for 'payor differentials' or discounts to other payers. A differential, actually a discount, is offered to certain groups of payers who demonstrate "quantifiable economic benefit" to the health care system.

The Fund's Restraining Order petition charges that it suffers "the discrimination of being charged higher fees in order to make up for the discounts offered to others. In this connection United, a non-profit plan, is categorized with commercial profit-making insurance carriers as not being entitled to a discount for providing a socially useful purpose" (despite satisfying similar criteria as other plans receiving discounts). This discriminates against the Fund as compared with discounts available to Blue Cross, Medicaid, HMO's and Medicare.

Participants vs Non-Insured

Under the New Jersey regulatory DRG program, if member Restrepo and other Fund participants had no hospitalization expense benefits through United the New Jersey hospital rate payment program would require that the medical care recipient pay only the actual cost of the patient care received; not the higher DRG rate. A person without hospitalization benefits is only liable for the actual amount of standard charges.

Under the specific terms of the United's plan, the Fund cannot pay expense benefits *"in excess of such charges as would have been made in the absence of the Welfare Plan insurance."*

Under New Jersey regulations, a patient without any hospitalization benefits is liable to pay *only* the actual amount of the standard charges attributable to his hospitalization (or the DRG rate, if it is lower). However, Restrepo and other United Fund patients are ineligible for payment liability based upon actual charges. In Restrepo's case, the Hospital charged an amount that comes to $2,103 in excess of the billed actual charges for the services provided him.

If the Fund abides by the mandate established by the Plan, *"to pay only such charges as would have been made in the absence of the Welfare Plan insurance,"* Restrepo and all other participants hospitalized at St. Joseph's would be liable for all excess charges and are discriminated against by a higher billing rate *"simply and merely because of their membership in United"*. On the other hand, if United paid the full DRG price, above the actual cost of medical care received, the Fund would not be in compliance with the Fund's plan and the Fund and its fiduciaries would be at potential risk for wasting assets.

A TAX IS A TAX, IS A TAX!

Under the zany New Jersey DRG regulations, some patients pay "actual costs" for their medical care while others—covered by Funds like the United Fund—are required to pay surcharges of often enormous amounts above actual costs. But hospital and health officials bit their tongues rather than acknowledge that this surcharge is a plain, old fashioned TAX.

In its recent report to the Governor, his Committee on Health Care Costs had no problem with this; the surcharge is clearly referred to as a "little known tax on all hospital bills" to fund the Uncompensated Care Trust Fund.

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Federal Cost Shifting: A Continuing Trend

By Harvey C. Sigelbaum
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Steven M. worked in the non-union construction industry for over 25 years. Then he suffered a heart attack and became totally disabled. He was only 43 at the time. By the time he reached his 46th birthday he was eligible for Medicare. He had no health insurance through his former employer, only Medicare. Steven's wife was about 40 at the time Steven became eligible for Medicare. She and their children had no health insurance. She took a job in a union shop with family coverage.

Steven's heart condition worsened and he was informed that he needed a heart transplant. The bill was $250,000 and his wife's union fund had to pay the tab.

Why? Steven M. was eligible for Medicare, wasn't he? Yes, but this doesn't mean that Medicare will pay. In fact this scenario and others like it are the result of a continuing trend to pass the burden of health care costs from the public to employee plans including union funds through cost shifting.

Medicare Cost Shifting

Medicare cost shifting began as early as 1981, when Congress passed the first laws making Medicare the secondary payor to employee benefit plans. The Budget Act of 1981 focused on a relatively small population—those with kidney disease. Medicare was made the secondary payor for kidney disease treatment (end-stage renal disease) for the initial twelve months beginning from the date of the individual's entitlement to Medicare coverage due to the disability. Under the Omnibus Budget Reconciliation Act of 1989, the employee plans' primary liability was extended to 18 months. The treatment of end-stage renal disease is a costly undertaking and much of the responsibility is now borne by employee funds.

In 1983 TEFRA (Tax Equity and Fiscal Responsiblity Act) went into effect. Prior to 1983 Medicare took primary responsibility for all claims incurred by Medicare eligible employees and their dependents over age 65. Under TEFRA, employee plans became primary payors for active, Medicare eligible employees and their dependents from age 65 through 69. This was a new population union funds hadn't previously covered and they were not able to prepare for the devastating financial impact that it caused.

Cost Shifting Extended

Two years later, the federal government extended cost shifting further. Under DEFRA (Deficit Reduction Act, effective January 1, 1985), employee plans became the primary payor for dependents of active employees, age 65 and 69, even if the active employee is under age 65.

Since DEFRA, two further regulations have been added to the trend, both under COBRA (the Consolidated Omnibus Budget Reconciliation Act). The first regulation, effective May 1, 1986, extended the fund's primary responsiblity to active employees and their dependents, age 70 and over. The second regulation which went into effect January 1, 1987, designated employee plans the primary payor for disabled, Medicare eligible, dependents of active employees and disabled employees under the age of 65. It was under this regulation that the cost of the heart transplant in the initial case cited here became the responsiblity of the wife's union fund. This is the case, despite the fact that the Medicare coverage for which Steven M. was eligible was available as a by-product of his employment with the non-union construction firm.

Not The Only Culprit

The Health Care Financing Administration, the federal agency responsible for Medicare, is not the only cost shifting culprit. In 1986, the Veteran's Health Care Amendments, shifted the cost of treatment in a Veterans Administration hospital or nursing home for military veterans for non-service related ailments. It would now be borne by their employer's health plan or their union benefit fund. Furthermore under CHAMPUS (Civilian Health And Medical Program of the Uniformed Services), the program which provides health care coverage to retired members of the armed forces and families of members of the armed forces (retired and active), coordination of benefit rules state that CHAMPUS is generally secondary to any employer provided or union health plan. This is true regardless of whether the person covered by the union fund is the member or a dependent.

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A New Medicare Approach Could Benefit Union Funds

There are doctors inside your claims system, and they are stealing your Fund's money. And guess what; you are paying them to do it.

If that were literally true, Fund managers across the country would be pulling the plugs on their computer systems—along with most of their hair.

Unfortunately, the 'usual, customary, and reasonable (UCR)' schedule that most Funds employ can produce precisely the effect of 'stealing' or certainly of overcharging Funds and serving the interests of the providers.

The HIAA Fee Schedule

The Health Insurance Association of America (HIAA) fee schedule approach is dominant in the insurance industry and is widely purchased and used by self-insured Funds and their TPA's as well. The HIAA fee schedule is based on the UCR method of fee determination. Under UCR, the prevailing charge made by physicians of a similar expertise, in a particular geographic area, for the specific procedure is the reimbursement rate for that procedure. Since the physicians' charges are the central component of the fee determination, the schedules are clearly provider-driven and inflate endlessly as the physicians raise their fees.

It used to be typical to pay 95% of the HIAA's UCR level. Then many Funds went to 90%. Now it is not uncommon to use 80% of the UCR level. But no matter how much Fund managers ratchet down the UCR, the payment rate seems to rise that much faster. That should not be surprising since, although Funds pay HIAA for the privilege of using the payment schedule, it is the doctors that really control the system.

Medicare To Zero In On M.D. Fees

The good news is that there may well now be an alternative for UCR schedules. Medicare, feeling somewhat successful in the hospital front of the cost containment battle with its DRG system, is now focused on doctors' fees. Medicare's new payment schedule, set to be implemented January 1, 1992, is called **'resource based relative value scale (RVS)'**. The new program will incorporate an evaluation system that emphasizes hands on, diagnostic patient care over specialty services.

Primary care providers will reap the immediate monetary benefits of RVS, whereas, specialists will receive lower payments. The goal of RVS is to reward providers who spend more of their time treating patients. This reflects a growing emphasis on managed care and preventive medicine in the United States, stressing primary care above specialty care.

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Changes For Medicare Eligibles Effective January 1, 1991

As a result of the 1991 budget bill, several important changes in Medicare regulations applying to covered members became effective on January 1st:

- MEDICARE HOSPITAL DEDUCTIBLE (PART A): Beneficiaries will pay a hospital deductible of $628 per benefit period. The deductible for 1990 was $592. Except for the deductible, Medicare will pay all reasonable costs for all medically necessary inpatient hospital services up to 60 days per benefit period. After 60 days, and up to 90 days, beneficiaries will be responsible for making co-insurance payments of $157 a day.
- MEDICARE PAYMENTS (PART B): The premium for coverage of physicians bills will rise from $28.60 a month to $29.90 a month. Part B generally pays 80% of the approved charges from a physician after an annual deductible of $100 is paid. The deductible for 1990 was $75.
- MEDIGAP INSURANCE REFORM: Under the new rules, insurers cannot sell a Medigap policy to anyone who already has one. Also, beneficiaries will have six months from the date of their 65th birthday to buy Medigap policies without passing a medical examination.
- MEDICARE CLAIM FORMS: One change, which became effective on October 1, 1990, requires all physicians who treat Medicare patients to complete the paper work on behalf of their patients. Previously, only participating physicians were responsible for completion of Medicare claim forms.

New Medicare Changes

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Medicare Will Set The Rates

Significantly, RVS pegs costs for services and places limits on future increases. As a result, the government—not the providers—will set rates of reimbursement.

Like DRG, RVS is a potent cost control tool that Funds may wish to employ. And like DRG, it is likely to become a standard, exercising pervasive control in the marketplace—a very welcome development indeed.

A 5-Year Phase-In For RVS

Medicare will start RVS on January 1, 1992 as the beginning of a phase-in scheduled to take five years. Although RVS is the key component, other changes are also incorporated in the Medicare Part B reform. These other changes help to round out the RVS payment program. They include:

- the creation of Medicare Volume Performance Standards to be used to determine fee updates and limit allowable increases.
- setting reimbursements for non-participating physicians at 95% of fees for participating physicians.
- limitations on balance billing.
- the creation of a new public health service agency to oversee research on outcome measurement and practice guidelines.

Union plans may not find it practical to jump right into the RVS system. There are other measures to be considered in gaining control over providers' charges.

Other Steps Are Available

The Amalgamated Clothing and Textile Workers Union, in conjunction with the Amalgamated Life Insurance Company has taken such a step with the development of Amalgamated Life's Health Care Network, a surgical preferred provider organization (PPO). Amalgamated Life's Health Care Network is a cooperative effort between Amalgamated Life and surgeons across the country to enable Fund participants and their dependents to obtain the highest quality health care, while containing costs for both the Fund and its members. Surgeons in the network, designated as preferred providers, have agreed to accept payment at the level set by the Fund as 'payment in full'. The development of this program has enabled the Fund to fix surgical costs at 30% to 40% below usual and customary rates.

Although a preferred provider network is not identical to the RVS structure, it does mirror both the goals and the desired effects for the Medicare format. A PPO, like the Amalgamated Health Care Network, allows for greater control of costs in an environment where cost escalation is rampant. Finally, effective cost control is of paramount importance as union Funds negotiate to preserve benefits.

Gov. Florio Opposed On Plan For Uninsured

The Florio administration's 28-point health care reform plan, including proposals to meet the problem of funding for uninsured patients, has met with strong opposition from business and labor groups.

Among other things, the Governor's proposals would extend for one year the currently lapsed fund for compensating hospitals for care provided for non-insured patients. Key to the problem facing the Administration is the deadly fear of proposing new taxation. In addition to opposition from the business community, and in the face of lawsuits brought by organized labor challenging the current system, Gov. Florio faces a warning from key legislators that they will not stand still for a 'fast deal' and insist on sufficient time to consider all of the proposals in detail before acting.

The now-lapsed Uncompensated Care Trust Fund, which was financed by a surcharge on hospital bills, came to 19% last year. Experts anticipate that if continued through 1991 it would rise to almost 25%. A commission appointed by the Governor in 1991 produced a report recommending proposals including a tax on employers amounting to $450 million, to replace the Uncompensated Care Trust Fund. But few, if any politicians believe such a tax is now possible, given the intense public anti-tax attitudes.

Organized labor has consistently favored a general revenue tax to finance health care for the uninsured, objecting to continuation of the current system of placing surcharges on the actual cost of medical services.

Federal Cost Shifting Drains Funds

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Take Dave W. He is 50 years old and needs a heart by-pass operation. Dave W. is retired from the Army; he has coverage through CHAMPUS for himself and his family. Susan, Dave's wife, also works. She is employed by a shop which offers union health benefits for her and her dependents. Dave has dependent coverage under his wife's plan. The union coverage is the primary payor for the necessary operation under the law, although he is employed by the armed forces. In essence, his wife's union fund is picking up the tab for a retiree of another employer, and that employer is the US Army!

Cost shifting from the public to the private sector can be viewed as a hidden tax on employers, as employers are paying to cover more and more of health care costs which should fall under the responsibility of federal programs. Employers and union funds are, in effect, paying for Medicare once through taxes and again by being primary. Compounding the problem, as cost shifting became more prevalent, advances in technology and more frequent use of this technoloy has increased the cost of care. For instance, to return to the initial case, when Steven M. became disabled, heart transplants were generally not available. By the time the transplant procedures had become commonplace the responsibility for the cost of Steven's care had been transferred from Medicare to the union fund. Knowing that that kind of technology was on the horizon and would hail a significant impact on Medicare cost, may have prompted the government to act as they have.

As health care costs continue to increase, the coffers of union trust funds are straining. The added burden of populations which previously were the liability of the government could threaten the benefit funds unions have built for their members. Everytime you read about the need for Medicare to cut costs, you can be sure that cutting costs means shifting costs and shifting costs mean increasing burdens for the union workers.

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